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ORIGINAL LECTURES.

THE PRESENT NEEDS OF SCIENTIFIC MEDICINE IN NEW YORK CITY.

The Inaugural Address of the President of the New York Academy of Medicine, delivered February 7, 1889.

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FELLOWS OF THE ACADEMY: As I review the good work that has been done in the Academy during the past four years, under the guiding hand of Dr. Jacobi, I am impressed with the fact that he has inspired all its departments of scientific work with his own indomitable energy and broad culture. He has laid the foundations of a far more comprehensive structure than existed before. He has striven to make this Academy the centre of scientific medicine in this city—I might say, in this country. His labors have been unremitting, disinterested, and self-sacrificing, and he leaves the presidential chair with the highest esteem and gratitude of all its Fellows. How successfully the work which he has so ably begun was continued, must be told by those who years hence shall write our history. It is our hope and purpose that the "well done," with which history has already sealed the record of the past, may not be denied to the future.

I desire this evening to speak to you of "The Present Needs of Scientific Medicine in this City," and through you to the noble and broad-minded men and women whose hands and hearts are in every enterprise that tends to make our city the centre of material power, art, science, literature, and human charity.

It were perhaps more fitting on such an occasion as this, to indulge in mutual congratulations, rather than in criticisms; to recall battles won, storms that are past, and to speak of the brightening skies that overarch our present successes, but to those who battle for science the time for congratulations comes only when there are no new problems to be solved, no more wrongs to be righted, no faults that may be corrected, no needs that may be supplied, no new fields that may be explored, where faithful workers may perform greater achievements than have been reached in the past—surely no one who reads with intelligent insight the lessons of the past quarter of a century, and who realizes the necessities of scientific workers in every department of human knowledge, can fail to be impressed with the conviction that a higher and broader culture is needed in those who are entering these fields of labor, and in no one is this more apparent than in that of medicine. That there have been great advances in this respect during the past twenty years, few will question, but that the standard is still far below what it should be, is equally apparent.

The remedy for this is somewhat difficult to reach; certainly the entrance examinations to our colleges which have been proposed do not solve the problem. It seems almost ridiculous that a few questions in mathematics, the elements of physics, and the rudiments of language, less difficult and less comprehensive even than those required for entrance into our academic colleges, can be a satisfactory criterion of a candidate's fitness to commence the study of medicine. It is to be remembered "that a quarter of a century has wholly changed the relations of human knowledge," and that the natural sciences have become the chief factors in our modern civilization. Medicine, which once relied upon authority and tradition, is now rapidly seeking for its basis the natural sciences; medical students, of all others, should have a special education in these sciences; so long as a special training is not required as the important part of the preparation for entering upon the study of medicine, so long will the instruction in our medical colleges be incomplete and unsatisfactory. Defects in early training cannot be made good by excellence of professional teaching; mental equipoise, keenness of perception, analytical acumen, and intellectual power of differentiation between fact and fancy cannot be developed after the mind has become dwarfed during its years of plastic growth. To make cultured physicians, our colleges must be furnished with cultured men.

The remedy then lies more in the hands of the profession than in the colleges; when the profession shall realize their responsibility in this matter, and shall refuse to send to medical colleges, or advise to enter upon the study of medicine men devoid of natural talents, mental discipline, and intellectual power, then will the colleges be furnished with material capable of receiving the instruction which they have to give. In England, and on the continent, the higher general culture of the profession has so influenced the mass of medical men, that no uneducated man thinks of entering upon the study of medicine.

This is the first demand which medical science makes of us, that our "*esprit du corps*" be more sensitive, that our sense of personal responsibility be more keen, and with a courage born of conviction, and strengthened by the nobility of our calling, we hesitate not to say when occasion permits, "You are not fitted to be a physician, choose some other path of life." When we stand ready as a body to take this position, then, and not till then, will it be possible for our colleges to do that high grade of scientific work which is justly demanded of them. For, while we are justly proud, and have ample reason to congratulate ourselves on the many advancements that have been made both in graduate and post-graduate instruction in our city during the past twenty years, and while we are fully abreast, if not in advance, of our sister cities in this matter, we are still far from meeting the demand of scientific medicine; to answer fully its demands, the teaching bodies in our colleges must be placed on a higher plane, they must be separated from the financial interests of the colleges, vacancies in the

corps of instructors must be filled by fair competition, thus stimulating the younger members of the profession, who desire to make teaching their lifework, to prepare themselves by study and training to fill vacancies in our faculties as they shall occur. The curricula of our colleges must be so extended and subdivided that not only will a larger number of instructors be needed, and longer sessions required, but what is of far greater importance, that those who teach may by personal and familiar contact gain such intimate knowledge of each student, and firm control of his mental processes as will enable them to become teachers in the good old Anglo-Saxon sense—to be educators and not simply instructors pouring out their daily dole of wisdom into unreceptive ears.

All the facilities for laboratory work, original research, pathological study, clinical observation, and bedside instruction must be systematized, and largely increased. In fact, our medical colleges must be turned into workshops of scientific medicine, with skilled master workmen in every department, to guide, to lead, and, if necessary, to goad the young apprentice through his daily round of labor, until perfected, he shall go forth fully prepared to take an honorable place among the masters of the land. Not only should our colleges be thoroughly equipped with teachers and appliances for the training of undergraduate pupils, but they should be prepared to give well-trained men, after they have completed their graduate course facilities for study and experimentation in new fields of investigation.

Our laboratories should be so endowed that scholars of rare ability who are every year coming to our city for more knowledge may not only have places to work in, but means to work with.

Why is it then that in New York City, the centre of all honorable activity, where wealth groans for an outlet, any institution of human learning should be unable to do good work for the lack of money to do better. Why is it that men of wealth do not realize their great opportunities for wise liberality in this direction, liberalities which will not only shed lustre upon themselves and our city, but will mitigate human misery as certainly, and in many ways far more effectually than our hospitals and charities for the sick and suffering poor? My answer to these questions is, that the medical profession has not, as it should, directed the stream of accumulated wealth into this channel. The only appeal, until quite recently, has been for means to establish hospitals and charitable institutions, that to-day hospitals and dispensaries so far exceed the needs of the city that there is actually a premium on patients to fill their wards. Does any one doubt that if the profession would unitedly urge the great and pressing needs of our educational institutions upon generous minded men and women, they would respond as liberally as they have done for the erection and endowment of hospitals and dispensaries. If educated men and women by their words and writings would create a public opinion that a higher education in every department of human knowledge is the only lasting glory of a great city, that mental development is more to be desired than material prosperity, and that next to religion, education is the great corner-stone of our civilization, then would science break the bonds which now bind her, and be able to offer to knowledge-seekers who come to us from every portion of the civilized world, equal facilities for growth and development as are at present furnished by the centres of learning in the old world.

History tells us that the greatest glory of ancient cities, long since buried in ruins, was their universities and lyceums founded, reared, and fostered by the patronage and intelligent generosity of wealth and power. It is hardly possible to believe that this great city will much longer remain uncaring and unconscious of her greatest glory. The noble gifts which have been made during the past few years to educational institutions, and especially to medical colleges, inspire the hope that the stream of emotional benevolence for the sick and suffering is being turned into intellectual channels for higher educational needs and may we not believe that in the near future this city shall produce a class of medical men of broader culture who shall enter on their lifework from a higher plane, carrying with them to the couch of suffering better skill, greater devotion, and a more comprehensive realization of the nobility of the work to which they have given themselves?

In this connection there is need of establishment of scholarships, fellowships, and independent lectureships, which shall enable scholars of limited means to engage in scientific work. It is a part of history that as a rule the most faithful and efficient scientific medical work in this city has been done by men who, in their earlier professional life, had only such opportunities as they made for themselves, who were hampered, often almost to the verge of despair by their lack of means. While appreciating most fully the value of adversity in developing character, I believe it may be carried too far and that many stewards of idle millions will one day give an account for their failure to supply abundant means whereby brilliant men may be enabled to develop their full powers for the benefit of science and the common good.

There should also be created a public medical opinion which shall cause scientific attainments to become so much more honorable than mere professional success, which so often depends on social rather than mental powers, as to induce young men of wealth and intelligence to devote their lives to study and research. Such work might well be done in connection with our colleges or under the auspices of our medical societies. If there were twenty such places of work to-day, I am confident they would be quickly filled by enthusiastic and intelligent workers; and who can estimate the amount of good that would be done each year, and the great influence it would have in unveiling the obscurities which surround so many of the vital problems now pressing upon us for solution in almost every department of medicine?

Another need of scientific medicine in this city in common with that of our country—I may say the whole world—is a higher standard of medical literature. The American spirit of so-called enterprise presents no more deplorable manifestation than in the development of our medical literature. Before entering upon its criticism, however, let me say that no one appreciates more than I the value of the work of many faithful and conscientious laborers in the field—laborers whose writings are the expression of crystallized thought and experience, whose patience never fails, who know no self but only mankind, and who, with a supreme reverence for knowl-

edge and truth for its own sake, are devoting their lives to its development—it is because I recognize the power and greatness of such lives that I feel impelled to offer words of criticism on the redundancy of the medical writings of these latter days.

The *first* fault which I would name is vain repetition, "such as the heathen uses," and a lack of original thought. Our medical journals are filled with articles that show haste in their preparation and a lack of careful consideration in their statements—positive opinions are given unsustained by reliable data or extended observations, theoretical conclusions are put forth as established facts and not as questions demanding experimental answers. It were almost a work of supererogation to demonstrate to this audience that our medical journals too often publish articles that contain not the faintest trace of an idea which is not familiar to every student of medicine. So called original articles, clinical lectures, reports of special methods of treatment, all repeat the well-known facts that are found in every "Student's Compend," until we despair of finding the little gold among so much dross. To what shall we look for the cause of this?

First. A mistaken idea among the younger members of the profession. An idea for which many of us whose heads are silvering are in part to blame. The eager, ambitious young man, fresh from the hospital, filled with his own knowledge and exuberant life, imagines that the road to fame and wealth lies through the columns of the medical press, and that all who have once seen his name at the head of an article, remember it as though it were the writing upon the wall, and will immediately seek his services in consultation. Too often his ideal is given a halo by some older man who says write something for the journals, write often and let the profession know you. Let us confess this in garments of penitence, and in a more loyal spirit let us seek to inspire the younger members of the profession with higher ideals which shall foster in them the spirit of personal achievement, shall develop a pride in quality—not quantity—of mental products and that praiseworthy modesty which is content to learn until it is competent to teach.

The story or legend of that German savant who, after a life devoted to the five cases of the Greek noun, mourned upon his deathbed that he had not confined himself to the dative case alone, comes to us like a fairy tale or the record of an insane asylum. Yet let me tell you within that story, be it fact or fancy, lies the secret of noble achievement, of human progress, the essence of expanding, perfecting life of scientific work. It shows the soul capable of comprehending the infinite possibilities of science, and the self-forgetting ambition which can devote itself to the accomplishment of one thing worthily, whose sufficient reward is in the consciousness of having done faithful work.

When medical writings shall be filled with this spirit a year of the journal medical literature of the French, German, and English speaking people can no longer be condensed into five small octavo volumes.

I mention as the *second* cause of medical redundancy the speculative interests of medical publishers, financial necessities of unsuccessful physicians, and conceit of self-appointed authorities—each of these offers excuse for the establishment of a new medical journal and another waif is born to feed on patent foods and peptonic mixtures. The doors are thrown wide open and all aspiring young authors invited to enter, without cost, where fame is found at every turn.

Gentlemen, I appeal to you, are these the hands by which our noble science shall be upheld: are these the spirits to suffer and endeavor to work for a lifetime, if need be, that one new truth may be added to our store? They bring but broken stones and rotten beams which are not worthy a place in our temple of science, whose walls bear polished tablets to the memory of men who labored for truth not titles, for science not self, for mankind not money, for love not lucre.

As one enters upon an analysis of these requirements of higher medical culture and the demands of scientific medicine, he soon finds the essential element of each crystallizing into a single form about a single point, and realizes that the fundamental defect, the one first cause of the established fact that medical science has failed to keep pace with her sister sciences in this country, is a lack of high ideals among the mass of the profession—too often also among those who are justly its leaders.

As artisans we yield the palm to none—when science passes into art we seize every weapon it offers and wield them against the common adversary with such fearless force and skill as to cause even the forgers of these arms to confess our greater skill. But in the fields of pure science we still sit at the feet of the old world and in our secret heart at least confess we are as yet hardly competent to be even critics of its teachings. As a body we have yet to learn what scientific work means. That practical spirit, that Yankee ingenuity, born of adversity and developed by opposition, which has made us the foremost nation on the globe in all that tends toward material prosperity, and our growth, like the unfolding of a century plant, are the very elements that check—nay, forbid the growth of pure science. Every other science but ours tends directly toward the production of material results, toward the production of wealth. It is America that has seized Jove's thunderbolts and bounded them in the service of mankind; has made them meek and patient servants that do our bidding as does the muzzled ox, because the harnessed lightnings draw out the golden shekels. But he who seeks to bind in scientific laws the lightning of the mind or trace the labyrinth that lies twixt cortex and medulla, must never hope to see the gleam of gold; he feeds alone upon the thought that generations yet unborn will one day know the worth of all his patient work and will rise up to call him blessed.

It is not to be wondered at that the medical profession has been borne along with the multitude and has been given over to the search for patients and fees rather than bacteria and ptomaines. But it seems to me that the time has come when not the few (and all honor to these few who have been the advance guard) but the many should be given higher ideals; should be lifted to that higher plane where intellectual work is valued for what it produces new. No man surpasses his ideal, and before we excel in pure science our ideal must be one of intellectual power and not of material prosperity. But such ideals are not of individual creation like cathedral towers to be raised above contamination of earthly things into the clearer upper air, they must be the product of many hands and many minds, of united and concerted action. This seems to me the mission of our Academy, to be both the artist to conceive and form, and the guardian to preserve and sustain an ideal medical spirit of the

profession of this city and our country. No great conflict is ever waged successfully without one controlling mind: we have in this city many strong minds, but they are like an army of undrilled recruits, much of their work is rendered useless because unconcerted; often it is simply repetition which might have been avoided, and the general result is weakened in authority and lessened in value, because often incomplete and defective.

Medical men need a "clearing house," as much as do the banks; they need an exchange where each may bring the results of his work, and learn what his fellow-worker may have done in way of support or opposition, and most of all we need a controlling spirit, a head to plan lines of attack, to bring together the scattered forces for their own and the general good. It is my ambition to see the Academy occupy this position, standing as the centre about which all the workers of our city may gather, giving them in return loftier ideals, inspiring in them stronger ambition to be truly scientific men, while it not only encourages, assists, and stimulates them to better work, but also rewards every praiseworthy achievement.

In order that our Academy may thus become the centre of the scientific activities of the entire profession it must have a suitable home, a building that shall furnish accommodations for a large and well-selected library, with reading rooms and commodious meeting rooms for all the medical societies of the city. Such a building the Academy is now struggling to establish. Our organization is no longer an experiment, it has passed successfully through the perils and contentions of its infancy, childhood, and youth, and is now entering its full manhood. The spirit of devotion to a high scientific purpose which actuated its founders and which has always been one of its characteristics, has caused it from year to year to grow in professional esteem and public confidence until it may be truly said that it is the strongest power in this city for the advancement of scientific medicine. It has outgrown its building accommodations, its library can no longer find shelf-room and is constantly exposed to destruction, the building not being fire-proof. Its Sections crowd upon each other to such a degree that their work is crippled, it is unable to do the good work it might do on account of its limited space. The need of a new Academy building with a fire-proof section for our library is an urgent one, and if we shrink from our responsibilities in this matter, we shall prove false to the legacy received from those who gave so much of labor and sacrifice to bring it to its present growth and usefulness. As we recall the many distinguished men with whose lives it is interwoven, and who did so much to make it a centre of medical thought, are we not stimulated to greater endeavors, to greater sacrifice, to an energy akin to enthusiasm which never rests until it has realized the great thoughts and possibilities which gave it birth?

What has already been accomplished gives assurance of ultimate success; never before have its Fellows been so united in opinion as to the immediate necessity of a new building. The Academy funds, with the pledges of money which have already been received, leave little doubt that before another twelve-month it will have a new building in every way adapted to its scientific work. To the accomplishment of this, let each Fellow give himself heartily, not only by contributing himself, but by interesting his friends and gaining donations from them, for, as has often been stated, each citizen is personally interested in everything that shall advance medical science.

If the profession in this city can have free access to a large and well-selected medical library, with a scientific centre where they can contribute new observations, new facts, and new methods of treatment, subject to the criticism and judgment of their peers, and where each one shall criticise in a scientific spirit the offerings of others, the public will receive in their medical attendants greater skill, more careful and intelligent observation, and as the medical profession as a body shall rise to a higher plane of scientific worth, the sick will turn less frequently to empirics for relief in their hours of suffering and in their struggles with disease. The sanitary safety of our great city will no longer be committed to unprofessional and unscientific hands, but will seek the protection of a broader spirited and more enlightened profession, who, by wise councils and more practical methods, shall protect it from the ravages of those diseases which it is being demonstrated each year may be limited, if not altogether prevented, by the new and more advanced methods which are being formulated by a broader and more perfect sanitary science.

It does not seem possible that men of wealth, whether selfish or broad-spirited, with such and kindred thoughts before them, will long hesitate to furnish the required means not only to build a new Academy building, but for so increasing its library that it shall become the central attraction for scientific workers in our city and the whole country.

But, gentlemen, I would not speak only of the material interests of the Academy, of its building and library, I would congratulate you on the broader spirit which is being developed in its membership; we are each year becoming more tolerant toward the opinions of others. The links which bind together junior and senior members of the profession are being forged with greater strength. The jealousies and intolerance of cliques are fast giving place to liberality and good fellowship. The questions now asked concerning a Fellow are not of his birth or of his school, but "has he done good work, and is he likely to do more?" We rejoice in no medical politics, or medical ethics; a scientific atmosphere is pervading everything that is being done. Men, who heretofore have stood aloof, and who have done their work in special societies, are coming into its Sections and making them effective. This centralization should go on until in the Academy would be found all the best thought and the best work of the entire profession. Let it become the fountain from which shall flow the purest streams in every department of medical science, a place where the young and old, the savants and the young enthusiast shall cross swords in that spirit of deference which one scientific worker is always willing to accord to his fellow.

Treatment of Erysipelas.—DR. NOLTE (*Allgem. med. Centr. Ztg.*, No. 100, 1888) has in the treatment of this affection for years used mucilage of gum arabic with carbolic acid. The affected parts are painted daily with mucilage containing from a three to five per cent. carbolic acid solution, and allowed to dry.—*Therapeutische Monatshefte*, Jan. 1889.

CLINIC ON NERVOUS DISEASES.

Held at La Salpêtrière (Paris).

BY PROF. CHARCOT.

(Specially reported for THE MEDICAL NEWS.)

DIAGNOSIS OF CAPSULAR HEMIANÆSTHESIA AND HYSTERICAL HEMIANÆSTHESIA.

THE case of this woman, which I bring before you to-day, may appear a very common one, yet it is a very interesting one, as there is a difficult question to find out. This woman's age is forty-seven, her father died in two days from cerebral apoplexy; this is all her family history. In regard to her personal history, she has been quite free from all sorts of diseases until two years ago, when she was attacked by the disease which has left her in her present state.

One evening in June, 1888, going to bed, she felt her head to be very heavy; the following morning she was found in an unconscious state, which lasted, it appears, about fourteen days. When she then came to herself, she was completely paralyzed on the right side, the paralysis affecting at the same time the inferior portion of the facial nerve, the upper and lower extremities; traces of this paralysis still persist to-day. She came to herself, according to her statement, at the end of fourteen days; but she does not remember, for after her return to consciousness she remained for several weeks more or less completely amnesic, whether her inferior extremity began to move first, or whether, on the contrary, it was the upper extremity, which would be contrary to what we usually observe; nor can she say exactly at what time she began to walk.

For the past year she has remained in the state we find her in to-day—that is, a hemiplegia affecting the right face, upper and lower extremities, with the particularity that the facial paralysis has persisted longer than usual, for ordinarily it disappears with time. I shall even add that the facial paralysis has remained much more accentuated than the paralysis of the extremities, which is an anomaly in a case of capsular hemiplegia.

You probably will say, "Why, this is a simple case of capsular hemiplegia, with certain particularities of a secondary order." I think it is a case of capsular hemiplegia, but let me recall to your memory the fact that the internal capsule can be involved in its anterior portion, in front of the genu, or in its posterior portion. If you find a more pronounced hemiplegia of the extremities, it is because, in all probability, the posterior portion of the internal capsule is involved. When you have a case in which facial paralysis persists, and this is very rare, it is when the anterior portion of the capsule has been involved. The portion of the pyramidal fasciculus which concerns the inferior facial (cortico-bulbar fasciculus) passes in the capsule in front of the genu, while the cortico-brachial and cortico-crural fasciculi of this same pyramidal fasciculus are placed behind the genu, the first one very near the genu, the second a little behind the preceding.

These facts have been demonstrated by both anatomical and clinical observations, as well as by the experiments on animals, and particularly on the monkey, by Pitres, Franck, Horsley, etc. In this manner you will comprehend that in capsular hemiplegia you might have sometimes a predominance of the facial paralysis, or, in other cases, the predominance of either the paralysis of the inferior or superior extremities. In most cases, this paralysis involves every one of these parts, and rarely, I repeat it, does facial paralysis persist very long in ordinary capsular hemiplegia, for in such cases experience has demonstrated that the posterior portion of the internal capsule alone has been destroyed by hemorrhage or softening, while the anterior portion, the one which concerns the movements of the face, has only been compressed, and not destroyed.

In this woman, I think, we have to deal with a capsular lesion, which consisted of a hemorrhagic effusion, to-day replaced by a cicatrix; but this lesion has involved at the same time, and very much so, the anterior portion of the internal capsule, as well as the posterior portion of the same. These last have been less severely injured, for, contrary to the rule, we find that the inferior extremity has been more profoundly affected than the superior. I explain this as follows: The hemorrhagic centre was longitudinal and curved, one of its extremities injuring the internal capsule in front of the genu, while the other extremity occupied the very posterior portion, but involving in part the cortico-brachial fibres which are between the two preceding tracts.

Let me say one word in regard to the paralysis of the inferior facial: it is not always easy to find it out when slightly pronounced. Is it necessary for me to recall to your memory the fact that the region of the inferior facial alone is involved in paralysis due to central clots, and that the non-involvement of the orbicularis palpebrarum establishes a contrast between peripheral facial paralysis, for this last is total, and affects at the same time the superior as well as the inferior facial?

The second patient I now place before you suffers from peripheral facial paralysis, or paralysis *a frigore;* as you may see, he cannot close his eye on the paralyzed side, while our right hemiplegic by capsular lesion can do so, and closes very well her right eye. We must not forget, however, that certain lesions of the protuberance can involve the facial when completely formed, and produce a total facial palsy, which would resemble the one produced by a lesion of the facial nerve at its exit from the Fallopian canal, but this is never seen in capsular lesions, or lesions of the cortex, paralysis of the inferior facial alone is found in such cases.

As I said a minute ago, facial paralysis, when not very apparent, is not always easy to define, and demands great care. Our female patient has a facial paralysis on the right side; on the same side she is hemiplegic, the right labial commissure is lowered, it is the paralyzed side; it is, on the contrary, elevated on the opposite side, where you find the naso-labial fold well marked; these are all usual symptoms. I shall add, also, that the lips on the paralyzed side are thin, and the mouth linear, while they are comparatively thick and the mouth slightly opened on the opposite side.

In such cases we are sure of our diagnosis; but sometimes the deviation of the mouth is much less pronounced, and the existence of facial paralysis can be doubted. In such cases, especially if the patient is of a certain age, consider the wrinkles. You can see on our patient how those on the lower and upper lips and chin are numerous, very accentuated on the non-paralyzed left side, while on the right side the skin is quite even.

Again, in the upper portion of the face you will find that the wrinkles are the same on either side. Again, if you tell your patient to show his tongue, according to the rule, when drawn out it is deviated on the paralyzed side—that is, in our case, on the right side, but here it is very slightly marked.

Let me call your attention to the fact that in cases of hemiplegia in which the tongue is deviated, the two halves are equal, one as broad as the other; the axis of the tongue remains linear, not curved toward the side where the mouth is deviated, as we shall see exists in certain cases which simulate hemiplegia of the inferior facial with deviation of the tongue, and in which we have no paralysis, but a spasmodic affection of which I shall speak to you in a few moments.

The father of this woman died from cerebral hemorrhage; she, herself, has had a cerebral hemorrhage—this is all very natural. You all know that cerebral hemorrhage is an hereditary disease. But you will say again to me: Where is that great interest you attach to your case? Well, here is the difficulty which makes out of this simple case a very interesting one for the clinician. It is that our patient is absolutely hemianæsthetic on the right side, as absolutely so as is the hemianæsthesia of hysteria; hemianæsthesia is so very pronounced in her case that you can introduce pins in any part of her paralyzed side without her feeling the least sensation; not only is she hemianæsthetic to the touch, but also to cold, pricking, and special sensations; half of the tongue does not taste bitter substances; the right nostril does not recognize odors as does the left; the right ear does not hear as well as the left. And, finally, the field of vision is narrowed on *both* sides, as is seen in hysterical patients, and, according to the rule, it is not hemiopic.

I have examined the fields of vision of hysterical patients thousands of times, and I desire to impress it on you once more, as the occasion presents itself, that I have always found a *double amblyopia more pronounced* on the *hemianæsthetized or unilateral* side, but *never* have I found *hemiopia.*

It is not usual to see hemianæsthesia, especially such a pronounced one as that we have before us, in a case of capsular hemiplegia. Briquet has said that when we meet with a very marked case of hemianæsthesia, we, in all probability, have to deal with an hysterical patient; in fact, a total hemianæsthesia is a very rare event in organic hemiplegia due to a hemorrhagic clot that involves more or less directly the internal capsule. There is a tendency amongst the young members of the profession to restore the opinion of Briquet. There was a time when, in the presence of a sensory or sensitive hemianæsthesia, the practitioner thought he had to deal with a case of lead-poisoning or alcoholism, for it was then thought that these two conditions could produce a hemianæsthesia resembling an hysterical hemianæsthesia. It has been demonstrated to-day, however, that when hemianæsthesia appears in an alcoholic or lead patient, it is due to the coexistence of hysteria in the same subject. This being admitted, we asked ourselves whether these hemianæsthesias were not due to a capsular lesion.

Turck's observations and mine have demonstrated to us, that certain capsular lesions can produce hemianæsthesia exactly similar to that presented by hysterical patients. Certain clinicians, however, question to-day their existence, and say that capsular hemianæsthesia does not exist. So that, according to the opinion of Briquet, every time one meets in a patient a more or less developed hemianæsthesia, this is almost certainly due to hysteria, and even reveals this condition. Well, I protest against such an assertion. Alcoholic and saturnine hemianæsthesias do no more exist. But capsular hemianæsthesia still persists,—it is very rarely completely developed; but such cases occur, and the one you have before you to-day is an example.

Let me mention to you the anatomical conditions found in cases in which sensory or sensitive hemianæsthesia is produced in combination with capsular hemiplegia, according to Turck's and my observations. It is when the lesion is situated at the extreme posterior region of the internal capsule, behind the region where the cortico-crural fibres of the pyramidal fasciculi pass—in fact, in the region which I have designated under the name of "carrefour sensitif" (sensitive cross-road). This I said twenty years ago; I have repeated it many times since, and I think myself authorized to repeat it to-day; and I shall add, that this capsular hemianæsthesia, when very accentuated, does not differ very essentially from hysterical hemianæsthesia, and particularly as regards the field of vision: it is not hemiopia that you will observe in such cases, but it is the crossed, unilateral, or double amblyopia, exactly as in cases of hysteria. Hence, leaving out of the question saturnine and alcoholic hemianæsthesias, which have no existence proper, although there are still alcoholic and saturnine anæsthesias, you see that, in a clinical point of view, we have to diagnosticate between capsular and hysterical hemianæsthesia.

To the old anatomico-clinical observations which have been presented, we can add to-day the cases which were presented some time ago, by Dr. Ferrier, before the Medical Society of London. These three cases, according to the author, resembled in every possible manner the symptoms observed in hysteria, yet at the autopsy he found lesions which occupied the "sensitive cross-road" at the posterior part of the internal capsule. Quite recently, M. Dejerine has presented before the Society of Anatomy of Paris, the history of a patient who had had a sudden hemiplegia developed at the same time a hemianæsthesia of special senses and sensation, as found in hysterics, made its appearance. At the post-mortem he found a hemorrhagic clot occupying the most posterior portion of the internal capsule. It is true, that this clot was of recent origin, while the cases related at the Medical Society of London, by Dr. Ferrier, were cases in which the lesion was an old one. If the hemianæsthesia of special senses and sensations is not encountered more often, it is because the hemorrhagic clots in capsular hemiplegia very rarely reach the "sensitive cross-road."

What demonstrates that our patient is not hysterical, is the fact that on the same side where there are a hemianæsthesia and hemiplegia there is also a palsy of the inferior facial nerve; and I am ready to maintain to-day, as I have done on former occasions, that hysterical hemiplegia involves exclusively the extremities, and does not, as is often the case in organic hemiplegia, involve the region supplied by the inferior facial. In this opinion I am sustained by the experience of Todd, De Hasse, Weir Mitchell, and others.

Affirming a certain fact brings about contradiction. If

you affirm that in hysterical hemiplegia there is no involvement of the inferior facial nerve, you will find a certain number of observations come up, demonstrating that the inferior facial can be involved in hysterical hemiplegia. Let us consider the matter more carefully. Facial palsy, due to capsular hemiplegia, with deviation of the tongue to the paralyzed side, can be imitated, in hysteria, and renders the diagnosis very troublesome, by an affection located in the region of the inferior facial, and producing also a deviation of the tongue and mouth, which affection is *not a palsy*, but a spasmodic affection. I have called attention to this pseudo-facial palsy in one of my clinics, delivered in the early part of 1887, and have named it

UNILATERAL GLOSSO-LABIAL SPASM OF HYSTERICS,

and in such hysterical patients it is not a palsy we have to deal with, but a spasm of the muscles and tongue supplied by the inferior facial.

I now place before you and beside our hemianæsthetic and hemiplegic patient with involvement of the inferior facial, a man whose case we will study in comparison with the former. This patient, although a man, is a very well developed hysteric—he is a characteristic type of major hysteria. His mother died insane, he himself has been very unlucky in his life—has had all sorts of troubles; he was one of our revolutionary soldiers during the Commune, was captured and sent to jail. Since then he has been always in a poor state of health, and whenever he requested admittance into a hospital for treatment he was rejected as a malingerer. It is true, he often contradicts himself in his statements and sometimes lies, but we must not overlook the fact of temporary amnesia, which is a mental state often encountered in hysteria of adult man; it is the physician's duty to make out what is true in his statements from what is false, and we must not reject such a man as a malingerer before his case is thoroughly studied. But he presents a number of symptoms which cannot be simulated, such as pharyngeal anæsthesia, shortening of the field of vision—and all the series of accidents which would be very difficult, even for an expert, to place in regular order.

The more male hysteria becomes known, the greater tendency have we to examine more carefully patients that present themselves to us, who would be often sent away as malingerers. Malingerers have a great tendency to exaggerate to an extreme degree the symptoms of the disease, whether it be insanity or hysteria, and it is always by studying carefully these exaggerated symptoms that we are able to make out the simulation.

Coming back to our male patient, I have had the opportunity, in past years, to be present at several of his hysterical attacks, which, I repeat, were classical. He suffers at present from a hemianæsthesia of the left side, a shortening of the field of vision, and hemiparesis on the same side. The motor hemiplegia has been more pronounced than it now is; this man who presents the above symptoms has, in addition, a hemiparesis of the left inferior facial. When he protrudes his tongue, it is carried to a marked degree to the left side—that is, on the paralyzed side, as is found in organic hemiplegia.

You certainly will say to me, why, a paralysis of the inferior facial in an hysterical patient—that contradicts all that you have just said. Examine the patient more carefully; when his tongue is protruded it is deviated to the left side, but notice at the same time that the lingual axis forms a very accentuated curve, the concavity of which is turned toward the left side so that the tongue does not remain straight as in paralysis, but forms a curve, a hook; the left half of the tongue also appears thicker and less broad than the right side; while in cases of paralysis the two halves of the tongue are equally broad; these facts would be sufficient to indicate that we have not to deal with a paralysis, but with a spasm, or, more correctly, a hemispasm.

This fact is confirmed when you examine the muscles of the inferior facial region; if you ask the patient to contract the muscles, the wrinkles are then more accentuated on the left side, on the chin, upper and lower lips, or the cheeks, much more so than on the right side; the contrary would take place had we before us a paralysis instead of a hemispasm.

I say again that the writers who have mentioned the existence of a paralysis of the inferior facial nerve in hysterical hemiplegia, have not sufficiently studied those glosso-labial spasms frequently found in hysterical hemiplegia and which have not been found, as far as I know, in capsular or organic hemiplegia. Lately, again, a Dutch author has recorded a case of hysteria with hemiplegia and involvement of the inferior facial. Well, I think in this case, according to the details given, that this patient, who was suspected to suffer from facial paralysis, was quite unable to protrude his tongue out of his mouth; this is not seen in simple organic hemiplegia and I would think it to be a case of hemispasm. You will say to me: Why do you not admit that in hysterical hemiplegia, which resembles so much organic hemiplegia, there should not be a palsy of the inferior facial nerve? As long as one cannot demonstrate to me that these so-called hysterical facial palsies are not hemispasms, I shall stand by my opinion until the moment when facial palsy, which I do not believe to exist in hysteria, shall become correctly demonstrated to me. From what I have just said, you are enabled to see that a marked hemiplegia of the inferior facial nerve can aid you to diagnosticate an organic or capsular hemiplegia.

What can be the physiological reason which seems to separate so widely hysterical from organic hemiplegia? I have shown you, in former years, that in hysterical patients who can be hypnotized it is easy for you to develop in them, by suggestion, all forms of hysterical paralysis, yet you cannot produce artificially a hemiplegia of the inferior facial, while, on the contrary, it is easy for you to obtain a glosso-labial spasm, exactly similar to the one we observe in our patients. The glosso-labial hemispasm which you see in the man before you, is sufficiently accentuated to be recognized, yet it is not a perfect example of the condition, but the man I now bring before you will help me to fix in your mind the characters of these hemispasms.

This poor man became hysterical two years ago, as a result of fright; he came near being run over by a large cart, and since then he has had a glosso-labial hemispasm of the left side, which we first took for a paralysis of the inferior facial. A more careful study of his case, however, showed plainly the nature of the disease. The tongue is directed toward the left side, but is in such a state of contraction and stiff, that the patient cannot draw it out of his mouth; it forms a very curved hook,

the concavity of which looks backward and to the left; at the same time the face is deviated; but the labial commissure being drawn upward and to the left, and the mouth on that side being slightly opened, it is easy to recognize the spasm, for the upper lip of the same, or left, side is almost continuously agitated by small convulsive tremblings.

Let me add, that the glosso-labial hemispasm can exist alone, without being combined with hemiplegia, such as is exemplified by the patient I now present before you.

HYSTERO-TRAUMATIC PARALYSIS.

You know that I maintain that hystero-traumatic paralysis possesses sufficiently marked characters that allow it to be recognized in the majority of cases.

Here we present to you a young patient who suffers from muscular atrophy, non-spinal amyotrophy, which has been named by Duchenne de Boulogne hereditary muscular atrophy; in addition, our young lady is a classical hysterical patient, and has a hemianæsthesia of the right side. I showed you, a few weeks ago, the case of a woman who, after having struck her child in the face, felt her hand hanging: that was a case of hystero-traumatic epilepsy.

Our present patient, a few days ago, while awaiting her turn to be electrified, in the adjoining room, where the electrization is going on, placed her hand unconsciously on the strap which communicated its movement to a static electric apparatus, and the left hand was slightly pinched between the strap and the motor wheel. As soon as this was done, the patient, very much frightened, felt in her left hand and forearm a certain numbness, and four or five minutes later *only* did the paralysis of the fingers and wrist present itself. It was at this moment absolutely impossible for her to move her fingers and wrist, which fell without any trace of contraction. Absolute cutaneous anæsthesia extending as far as the upper portion of the forearm, and limited by a line perpendicular to the axis of the forearm, assuming the form of a long glove, and deep anæsthesia of all the parts were found to exist.

All this is very correct, but here is the interesting fact: on the right side, where the hemianæsthesia was total before the accident, insensibility has completely disappeared from the hand, wrist, and lower half of the forearm, sensibility has returned on this right side, in exactly the same region, which is the only part insensible on the left side. In this case we have a transfer from one side to homologous parts on the other side, such as is sometimes obtained by the applications of metallic plates or a magnet according to Burq's method. Hence, the transfer of sensation can be produced by a traumatism, exactly as if æsthesiogenous agents had been applied; this I had never observed before under such circumstances.

It will probably be very easy for us to obtain a cure in this case; you know that I believe that hysterical contractures or palsies must not be allowed, as far as possible, to remain very long; it is usually very easy to make them disappear when they are of recent occurrence, but it is not so easy when they have lasted for some time. Our patient can be hypnotized; she presents the three stages of major or great hypnotism; we shall probably obtain a cure of this affection during the somnambulistic stage, by suggestion, as we have done already in certain cases, although not so often as we would have desired it.

It is natural for us to infer that such a transfer of sensibility, as is observed in the preceding case, is not an anomaly, an exception, but we can find it in analogous circumstances. A few days ago the same occurred in an hystero-epileptic in my service, but I did not bring her before you, as she was, according to my view, cured as soon as the hystero-traumatic epilepsy made its appearance. Her history is as follows:

Young lady, aged eighteen, easily hypnotized, presents all the characters of major hysteria, with a hemianæsthesia on the left side. One Sunday, being angry, because the stove of the ward did not give off enough heat, she kicked it vigorously with her left foot, which was in a normal condition at the time. Immediately after she had kicked the stove, however, the left leg and foot became very heavy, accompanied by a sensation of numbness; and when the patient tried to put her slipper on, which had fallen off, she remarked that her foot was hanging and absolutely insensible. The same occurred in this patient as had taken place with the other, when she placed her hand on the motor strap, producing paralysis of the hand. The foot in this last case was also completely and deeply anæsthetized, with loss of muscular and articular sensation. In this case, a transfer of sensation had also taken place to the right foot and the inferior part of the leg, which had previously been in a state of hemianæsthesia, now presented a normal sensation; this girl was cured of her paralysis by hypnotic suggestion.

HYSTERO-EPILEPSY.

This patient I present to you now, was treated eight years ago by my excellent colleague, Dr. Labbé, for six months, for attacks of epilepsy. According to the patient's statement, he had an aura, a sensation of vertigo was the beginning of the attack, and he gradually lost consciousness. He does not remember whether he felt constriction of the neck, but he recollects that he heard, previous to his attack, a whistling in his ears. He has had as many as seven fits a day; some of them would last two or three hours and when he had a fit several men were necessary to keep him down—he rolled about, twisted himself in every possible manner, and broke everything that came within his reach: such are his statements. He has been cured since he left the hospital.

Well, gentlemen, according to the description given us by this man, I think I can state that we have not a case of epilepsy to deal with. When an epileptic has a fit he is more quiet, he falls suddenly in a corner somewhere, and he does not strike around him, as this man has done, and four men are not necessary to keep him down; moreover, the evolution of the disease, the great number of fits in a relatively short time, the existence of a special aura, and finally the absolute cure of the patient, all indicate hysteria—and major hysteria.

He has never had any fit in bed, but he now occasionally awakens with a sentiment of fear. Let us see if there are no remains of hysteria, no shortening of the field of vision, or anæsthesia. Asking him why he comes to consult us, since he has been cured of his fits, he tells us that when he wants to cross a large empty square, the larger the empty place is the more frightened he is; he is unable to move his legs, they are as if they were

cut—he says that they are like lead; in addition, he experiences an indescribable emotion. If I ask him whether he is able to get over his fear, and cross the place, he tells me he cannot do so, and he fears he would lose consciousness should he attempt it. When he desires to cross a bridge he has the same fear, but to accomplish this he follows a car, looking in its interior, and, says he, should he find that he was going to feel bad he would jump into the car, and cross the bridge in that manner, without knowing it. This state is called "agoraphobia," a special nervous state, which has been discovered by Professor Westphal, of Berlin.

When travelling on a railroad he is frightened, because he feels he is locked in; and whenever he is placed in a narrow space he feels uneasy. The other day when a train in which he was began to move he had the sensation of a vertical or perpendicular rapid descent and he quickly rushed out of the car at the risk of killing himself; but the annoyance of this sensation was so great that he was unable to control himself. This is a vertigo or hallucination of translation, which occurs in a very slight degree in certain persons; when at night, the train begins to move, we feel suddenly as if the train was going in the opposite direction, and sometimes as if we were going perpendicularly down. While crossing a bridge in a train, our patient has also thrown himself down on the floor of the wagon, not knowing that he was doing it. This belongs to the section of height vertigo. The same occurs when he finds himself in a very high house, and looks out the window: he has then a terrible fear, a great uneasiness.

This state of fear and vertigo has existed only since he has had his convulsive disease. This disease he attributes to a fright; three men rushed on him one night, which caused him a great fright, which was followed by tremor; but this I only consider as an occasional cause. He dreams, and he has sometimes thrown himself out of bed, dreaming that he was falling. He is unmarried. He tells us a very interesting fact of his family history—his uncle died insane after two attacks of insanity. Here we have the real cause of his trouble, heredity. This case is a very interesting one to study.

ORIGINAL ARTICLES.

SOME HELPS IN GYNECOLOGICAL PRACTICE.

BY W. A. N. DORLAND, M.D.,
OF PHILADELPHIA.

THE class of patients met with in the practice of gynecology is of such a varied character, and the pathological conditions, though somewhat limited in their number, are of such frequent occurrence, that in whatever locality the practitioner may settle, unless strictly confining himself to some specialty in his profession, he necessarily is called upon sooner or later to alleviate the sufferings of these unfortunates to whom seems to have been portioned more than their due allotment of the ills of humanity. Too frequently, when such emergencies arise, does he find that that special branch of his medical education has either been sadly neglected by his alma mater, or carelessly overlooked by himself, and that, no matter where the fault may lie, he is utterly unable to respond with any degree of intelligence to these demands upon his professional skill.

It is with the desire to be of some assistance to such that the writer has sought this opportunity of advancing the suggestions which follow, not laying any claim whatever to originality, but merely stating that as they have been, from time to time, presented to his notice, he has thoroughly tested them in both private and hospital practice, and found them to be valuable and reliable adjuncts in the treatment of the respective conditions.

They are as follows:

In the first place, it will be noticed that the great majority of these patients present a marked degree of *anæmia*, as evidenced by the blanched conjunctivæ and lips, and general pallor of the skin. This anæmia is accompanied by the varied symptoms of dyspepsia—eructations of gas, poor or variable appetite, sometimes complete anorexia, a bad taste in the mouth, and severe headache, generally frontal in character. In such, often a marked improvement is manifested in a short time from the judicious use of some tonic such as the citrate of quinine and iron in two or three grain doses three times daily, or the following:

℞.—Strych. sulph. . . . gr. ss.
Acid. phosph dil. . . . ʒij.
Liq. pepsin. . . . . q.s. ad. ʒiv.—M.

S. A dessertspoonful three times daily before meals. Under such treatment not only will there be a general improvement of the health, but the local condition will often be decidedly benefited.

Our attention will next be called to the *condition of the bowels*. These will generally be found to be constipated. Professor Goodell has said that, were he asked, he would define woman as "a constipated animal," and he would be justified in so doing, many women having but one or two evacuations weekly or even less, while a digital examination per vagina reveals large fecal masses widely distending the bowels. It is important that this condition be remedied, and this may be accomplished by the daily use of a drachm of the compound licorice powder taken at bedtime, or by divided doses of calomel, as the one-sixth of a grain in a small amount of the sugar of milk every half-hour till a grain has been taken, this amount generally proving sufficient to produce a free discharge of the hardened feces. In still more chronic cases we may employ one of the following mixtures according to the urgency of the condition:

℞.—Ferri sulph. exsic. . . . gr. xv to ʒss.
Magnes. sulph. . . . ʒij.—M.

S. A teaspoonful in a wineglassful of water with a little lemon-juice before breakfast.

or,

℞.—Aloin . . . . . gr. iij.
Res. podophyl. }
Ext. bellad. } . . . āā gr. iss.
M. Ft. Pil. No. xii.

S. One to be taken at bedtime.

By the employment of one or the other of these remedies, together with proper attention to the diet, the bowels may be easily regulated.

In almost every instance, *leucorrhœa* is one of the most prominent symptoms complained of. This may be simply the viscid, white-of-egg discharge of cervical endometritis, or the purulent and, at times, blood-streaked discharge of corporeal endometritis; or it may be the copious, thin, bloody, and offensive discharge of carcinoma, or the thin and purulent discharge of vaginitis, specific or otherwise. Whatever the condition producing it, it can only be properly treated by treating the cause. Where, however, this is not immediately possible, much can be done toward reducing the amount of the flow, and thus contributing to the cleanliness and comfort of the patient, by the use of the hot water douche. The patient should be advised to procure a fountain syringe, and instructed to inject, night and morning, a gallon of water as hot as can be conveniently borne, thoroughly up the vagina, lying upon her back at the edge of the bed with her feet resting upon two chairs, and a basin placed between to catch the water. These injections should be followed by a quart of hot water containing some astringent mixture, such as the following:

℞.—Plumb. acetat. . . . . ʒj.
Acid. borici . . . . . ʒij.—M.

Of this a teaspoonful should be employed in the injections. Considerable amelioration follows such treatment.

Endometritis is an extremely common affection, almost every woman presenting herself to the physician for examination revealing this condition to a greater or lesser extent; nor is it to be wondered at that such is the case, when we consider the great variety of causes, both predisposing and exciting, to which that delicate organ, the womb, is exposed. As to what these causes are and their degrees of frequency, the reader is referred to the text-books on the subject. Attended, as endometritis is, not only with local but also with marked general manifestations destroying the mental equanimity as well as the physical health and rendering life a burden to the wretched sufferers, it is all important that prompt and vigorous, as well as judicious and careful, attention should be given toward improving the condition of the endometrium in these cases. Much can be done in this direction by the use of the stronger (Churchhill's) tincture of iodine, the formula of which is as follows:

℞.—Potas. iodid. . . . . gr. xc.
Iodi. . . . . ʒijss.
Alcoholis . . . q. s. ad ʒiv.—M.

Applications of this made two or three times weekly, not only to the cervix but also to the canal, have a beneficial effect upon the unhealthy membrane.

When there has been a laceration of the cervix and considerable erosion and rolling out of the lips have followed, the iodine may be substituted by pure carbolic acid, to stimulate the eroded surface and bring it into a more active and healthy condition. Or an impervious coating may be formed over the raw surface, thus protecting it from the irritating leucorrhœa, by applying twice weekly the following preparation:

℞.—Iodoform . . . . . ʒj.
Acid. tannici . . . . . ʒiij.
Collodion . . . . . ʒij.—M.

The bearing-down pain, so often complained of in these and, in fact, in all uterine and ovarian cases, may be relieved by the use of the hot water bag placed over the small of the back, and retained there for a considerable portion of the day, renewing the water as the temperature falls.

In many cases of *retroversion*, where the use of pessaries is not advisable, and where radical operation will not be permitted, temporary relief may be afforded by placing the patient in the Sims' position, and after reducing the displacement as far as possible by the finger, inserting far up behind the cervix one or two cotton tampons well saturated with glycerine. These often have a very pleasing effect upon the backache, and render the patient quite comfortable for the time.

They are also very serviceable in cases of *chronic cellulitis*, where there is much deposit of exudation around the womb and in the broad ligament. The hygroscopic properties of the glycerine draw to it the watery portions of the blood, thus aiding greatly in breaking down the exudate and removing it. The tampons should be withdrawn, in all cases, in thirty-six hours, and their removal will be followed by a free watery discharge from the vagina.

When there is much *irritability of the bladder*, from whatever cause, as shown by frequent micturition and inability to hold the contents of the organ, a happy result may be obtained by the use of some diuretic such as the following:

℞.—Ammon. benzoat. . . . . ʒij.
Infus. buchu . . . . . ʒvj.—M.
S. A tablespoonful every four hours.

The free administration of this preparation will be followed by a marked reduction in the vesical irritation, much to the satisfaction and relief of the patient.

In patients suffering from *menorrhagia*, *metrorrhagia*, or from *continuous and excessive flow after*

abortion, a most happy result may be obtained by administering equal portions of the tincture of the chloride of iron and the fluid extract of ergot, in doses proportionate to the severity of the case, varying from ten to thirty drops of each every three or four hours. The bleeding is controlled very promptly and efficiently under the employment of this combination.

In cases of *ovaritis*, *salpingitis*, and *inflammation of the broad ligament*, accompanied with severe pain in the groin and elsewhere, as indicative of the presence of an acute inflammatory process, where operative measures may not be resorted to, much relief may be afforded by active counter-irritation. This may be accomplished by painting the cervix and the vault of the vagina with Churchhill's tincture, and applying over the painful spots in the groins the following preparation:

℞.—Olei tiglii . . . . . ʒj.
Tr. iodi . . . . . ʒij.
Ætheris . . . . . ʒv.—M.

This must be repeated until a thick crop of pustules is produced, the irritation thus made acting favorably in checking the pathological process within.

In severe cases of *follicular vulvitis* with all its distressing group of symptoms, a very prompt termination to the sufferings may be brought about by applying to the sores a solution of silver nitrate of the strength of thirty grains to the ounce. The pruritus is relieved almost immediately, and sloughs are formed, which, separating, leave healthy ulcers which quickly heal.

Silver nitrate also is very useful in cases of *hemorrhagic urethra* accompanied with pouting of the lips of the meatus and intense engorgement of the delicate membrane. When the silver fails to accomplish its purpose, carbolic acid will usually suffice, destroying the engorged capillaries and causing a contraction of the dilated orifice.

The above comprises, as has been said, a few observations which may prove of assistance to some. Such, at least, is the sincere wish of the writer.

1521 SOUTH THIRTEENTH STREET.

A CASE OF DOUBLE FRACTURE OF THE SKULL.

BY THOMAS H. MANLEY, M.D.,
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I OFFER this case to my professional brethren because it well illustrates the difficulties which often attend the diagnosis and prognosis of cranial lesions, especially those of a traumatic character.

B. M., male, aged thirty-five, fairly nourished, of medium size, was brought into the Harlem Hospital by the ambulance, at 2 A.M. January 6th. He was found, lying in a helpless condition, in an area, about eight feet beneath the sidewalk, by a patrolman, who was directed toward him by his groans. The officer, supposing him intoxicated, tried to arouse him, but did not succeed. He, however, discovered that the man was bleeding, from the head, quite freely.

After entering the hospital in a profoundly comatose condition, he was placed on the operating-table, when it was found that he had a scalp-wound above the ear, to the left, from which the blood freely oozed. The wound was enlarged by a crucial incision, and the surface of the skull carefully examined for fracture, but none was found.

He lay unconscious for nearly forty-eight hours, when reason gradually returned. The marked dilatation of the pupils disappeared; he changed from side to side, asked for food and drink, and, indeed, seemed to show evidence of returning health. This interval of lucidity, however, was of short duration, as he soon commenced to complain of pain about the forehead, and became more or less somnolent. At this juncture ten ounces of blood were quickly taken from the cephalic vein, hoping that this measure might abort the threatening meningeal trouble. He was much relieved by the venesection, brightened up, and said the pain was relieved greatly. Within ten hours he again relapsed into a stupor from which he could only be aroused with difficulty.

By the sixth day his temperature went up to 105°, and he was constantly muttering in a dazed, dreamy state. He would take no food, and had involuntary discharges. On the seventh day, for the first time, we found the pupil on the left side much contracted, the opposite about normal.

It was now evident that there was pressure somewhere close to the origin of the trigeminus, and that the brain-substance was being compressed by either pus or blood. I eliminated the latter, because of the patient regaining his reason, there being no paralysis, and the period at which those serious symptoms supervened. On the other hand, with the sudden rise of temperature, which was 105° in the morning, and went up to 105½° in the evening, I was naturally inclined to suspect an abscess formation.

On the afternoon of the 13th ult., the seventh day after his admission, he was again placed on the operating-table, the head having been cleanly shaved and scrubbed. At this time he was quite weak, and it was thought that if the difficulty could be reached life might be prolonged, but, at the same time, we also saw that the shock of operation would tend to enfeeble him more.

A free incision was now made through the old wound, all the tissues drawn away from the original incision, and the pericranium elevated, or rather *scraped off the skull*, thereby bringing the bare, denuded bone-surface into view, when a fracture was discovered, of a quite small area, triangular in form, at the junction of the temporal, parietal, and frontal bones; it was but slightly depressed. Over this rent the trephine was placed, and a large button of bone removed in pieces.

We were very cautious, in going through the inner table, not to wound the dura mater; but we found this care unnecessary, as between the inner surface

of the cranium and its fibrous investment there was a space of more than half an inch filled with a firm, compact blood-clot. A second circle of bone was removed, to make room for operating within the cranium, and thoroughly displacing this large mass of coagulated blood.

The index-finger was passed in, and the clot, which was well organized, was broken up and displaced. The finger was carried in every direction, down even to the petrous portion of the temporal bone, and, with the aid of the irrigator, every portion of this foreign body removed. After the removal of this immense mass, the brain did not expand in the least, and a large, hollow space was left.

Antiseptics were rigidly applied throughout. Now, that this effusion and pressure were removed, we looked for some hopeful signs from our patient, but our efforts proved futile. He became chalky-white, and the extremities cold; in fact, he was suffering from shock, with alarming depression of the vital powers. I raised up the lid of the left eye, and found the pupil *still contracted*, notwithstanding what had been done.

Besides my colleague, Dr. John G. Truax, there were several other medical gentlemen present, who, with myself, supposed the patient would have rallied after what we presumed must be a successful operation.

Heat and the usual restoratives were most assiduously applied, but he gradually succumbed at 8 P.M., four hours after the operation of trephining.

The query now very properly was, What caused his death? Was it caused by delaying the operation too long? It will be remembered that I had the assurance of the house-staff that no evidence of fracture could be found when admitted; hence I assumed that it was probably a case of concussion, until graver symptoms supervened. After carefully studying the matter over myself, I decided that he probably died from loss of blood during the operation. I thought it possible that, in displacing the clot, we might have reopened the vessel from which the original leak sprung; hence I made up my mind, if I ever should cut down on a similar formation, I would be more chary about removing it all at once.

We were fortunate in getting permission to open the head after death, when, to our amazement, we found a large fracture at the base of the skull, entirely independent of the fracture described, extending from the foramen magnum up through the occipital well into the perietal bone. No hemorrhage was found in the course of this fracture. The hemorrhage contributing toward the removed clot was found to have come from the vessels of the diploë pushing away from the skull the dura mater, as it increased in volume, until it had torn up a section of this membrane nearly as large as the palm.

This man then had, along with the fracture anteriorly, a fracture of the *base*, without a single symptom of this mortal lesion, if we except coma. No hemorrhage from the ears, no suffusion of the loose, cellular tissues about the eyes, and not the slightest paralysis.

The singular course of this quite unique case I believe to be of sufficient interest to publish, as such are rarely met with. I have now treated one hundred and fifteen fractures of the skull in hospital, but the peculiarities and puzzling features of any similar to the one recorded I have never before met.

THE CURVILINEAR REFLECTION OF WEISS AS A PRODROMAL SIGN OF MYOPIA.

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IN a paper read before the Heidelberg Ophthalmological Society, in September, 1885, Dr. L. Weiss discussed as "the earliest variation in the near-sighted or near-sighted-becoming eye," an appearance in the eye-ground to which he had called attention at the Baden-Baden meeting of the German Naturalists and Physicians in 1879. This appearance he described as a brilliant curvilinear reflection to the nasal side of the optic disk, and nearly concentric with it. Its length, breadth, and distance from the disk-margin may vary considerably, not only in different cases, but even in any given case with variations in the illumination. He differentiated it from the numerous flitting reflexes of the retina so marked at times in the eyes of children—the watered-silk retina of some English writers—by its form, its relative steadiness, and its relation to the inner margin of the nerve; but especially by its position decidedly in advance of the eye-ground. The more near-sighted the eye in a progressive case, the further out in the vitreous chamber would it generally appear, and the more widely to the nasal side of the disk. Examining the eyes of the pupils in a gymnasium and preparatory school in Manheim, with reference to the frequency of its occurrence, he found it in 20.6 per cent. of 446 hypermetropic, in 32.6 per cent. of 356 emmetropic, and in 69.4 per cent. of 292 myopic eyes—in 38 per cent. of the total 1074 eyes studied. It was, therefore, not at all confined to the myopic eye, although more frequently there seen; its importance lay in its marking the *distending* eyeball, whatever its refraction, and in furnishing a most valuable prodromal sign of myopia early enough to permit of combating the evil.

As to the causation of the appearance, Dr. Weiss claimed that it was due to the presence of fluid in front of the optic nerve entrance—fluid separating the vitreous from the retina over a limited area at the posterior pole of the eyeball—and that the curved boundary of this collection formed the surface from which the reflection proceeded. His investigations

of myopic eyes (*Mittheilungen aus d. Tübingen Augenklinik*, I. 3, p. 63) had shown such collections and a sharp bending of the optic nerve at its entrance—a condition likely to interfere with the natural outflow of the intraocular fluid, and to account for such a collection within at the posterior pole; and while regarding, with v. Hasner the traction upon the nerve-entrance exercised in convergence by a too short optic nerve as the prime cause of myopia, he held that the fluid thus detaching the vitreous was not only a symptom of the distention, but also, by its pressure, one of the factors in its production.

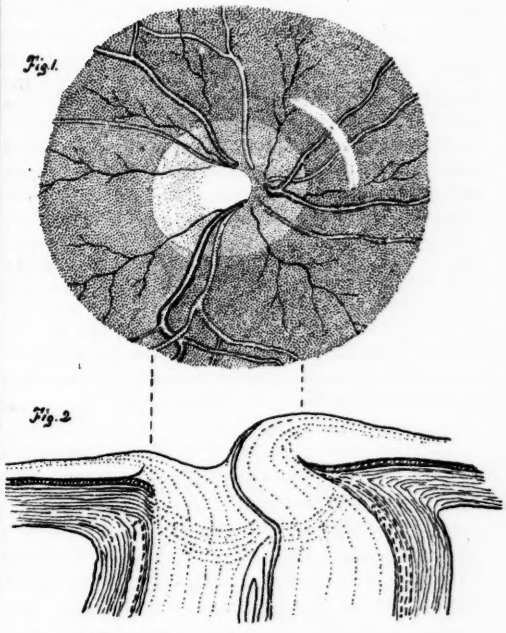
The pointing out of so important a prodromal sign of myopic distention by an investigator whose previous work had been so valuable, could not but challenge attention; and ever since Dr. Weiss's first note upon the subject, but especially since his later paper, which was published in full in Graefe's *Archives*, xxxi., 3, p. 239, the writer, like many others, doubtless, has been endeavoring to study the matter. The point was unquestionably a new one; and it seemed a little humiliating that in ophthalmoscopic work which he had flattered himself was careful, he had never taken cognizance of such an appearance. The total failure, however, to find it in hundreds of cases in which it was sought with scrupulous care had nearly changed his humiliation into utter scepticism; when a case came under observation, presenting so clearly the points of interest to which Weiss had called attention, that it has seemed proper to place it upon record, with some remarks upon a subject which has been little dealt with in English.

Sally L., aged eleven, came to the Eye Dispensary of the Episcopal Hospital on October 29, 1886. The brief and imperfect notes show that her myopic astigmation was measured under atropine, and her glass as given for constant wear was

$$\begin{cases} \text{O. D.}—3.\,5\,\text{sph.}—2.25\ \text{cyl. ax. } 150^\circ & \frac{20}{\text{LXXX}} \\ \text{O. S.}—1.5\ \text{sph.} & \frac{20}{\text{XL}}. \end{cases}$$

While the record fails to show full details as to the normal appearances of the eye-ground, the completeness of the paralysis of accommodation, or even that the full correction was ordered, it is safe to assume that the contrary would have been noted in accordance with the usual routine. She returned on March 2, 1888, complaining that her vision was no longer sharp through her glass; and examination showed a greatly lowered vision, especially on the right, due to an apparent progression in the myopia. Under full atropine mydriasis, the left eye showed unchanged refraction and vision; but the right eye now required —6 sph.—1.50 cyl. ax. 150°, and obtained a vision of $\frac{20}{\text{LXIV}}$. There was marked tendency to divergence of the right eye, which lessened materially under the use of the correcting-glass, but remained periodic, and gave rise to double vision. A tenotomy of the right externus was done after some weeks, there being full excursion of the eyes in all directions, with the result of greatly lessening the deviation; and several weeks after the operation diplopia had disappeared, the eyes could be maintained in parallelism, and the vision was better with both eyes than with the right eye covered. She did not return until recently, when requested to do so, having been comfortable; but examination now shows renewed deviation of the right eye and lowered vision, apparently due to still further increase of the myopia on the right side.

In March, 1888, her eye-ground presented the appearance shown in the cut (Fig. 1), and has



changed little, if at all, in the last nine months. The optic disk is horizontally oval, with a considerable central excavation, of which the nasal margin is abrupt and overhanging, while the temporal side shelves gradually. The disk margins are slightly veiled by retinal striation, but everywhere discernible, and show neither heaping nor notable absorption of pigment—although down and out there is slight broadening of the scleral ring and the disk is least clearly defined here. Most of the vessels pass through the substance of the nerve-head, as the central artery divides before coming into view; some of them come from beneath the overhanging margin of the excavation. The whole nerve-entrance presents some of that appearance of "drag" to which Thomson and others have called attention; and, in accordance with the usual findings in such cases, the ophthalmoscope shows a considerable difference of level on the two sides. The nasal margin

of the disk is between one and two dioptres more prominent than the temporal.

To the upper nasal side of the papilla, less than half a disk-diameter from the margin, is a strong crescentic or curvilinear reflection which nearly hides the vessels which pass beneath it. Variations of the illumination cause it to shift and alter slightly, but its character and position are quite as fairly fixed as those of the reflection from the *fovea centralis*. Like the latter and other retinal reflexes, it is best seen with a convex glass in addition to the correcting-glass, and almost disappears from view when the underlying retinal details are sharply focussed. Bright, shifting reflexes are visible elsewhere in the fundus, especially along the major vessels; but these are by no means so marked as they often are in the eyes of children, and have none of the constancy of the phenomenon in question. At the first glance into the eye the peculiarity and individuality of this crescentic reflection struck me, before any other details had been noted, and I remarked to my assistant that I had found something which I had vainly sought for years. Repeated careful examination affords no visible evidence of that "supra-traction of the choroid" of which Nagel and his pupils make much note; and while the oblique position of the disk is unmistakable, it is noteworthy that in spite of the foreshortening incident to this, and although there is no broad scleral ring or conus to its outer side, the disk still appears wider horizontally than vertically. The left eye shows an eye-ground similar in most respects; but the reflection, while present, is far less characteristic in form, and blends with the ordinary reflexes along the adjacent vessels.

The question of the causation of this appearance seems important. In view of the conspicuous character of the present condition, it is hard to believe that it could have been present at the examination eighteen months ago, and have been wholly overlooked, at a time when I was rather more on the lookout for it, having recently read Weiss's later paper. The study was at that time unsatisfactory in that only $\frac{20}{LXXX}$ of the normal vision was obtained; and it is quite certain, although neither the record nor my memory serves to prove it, that repeated ophthalmoscopic examinations were made in the endeavor to improve the correction, or to obtain an explanation of the defective vision. Probably, therefore, the curvilinear reflection has appeared since the eye has suffered the increase of some two dioptres in its myopia, and is dependent upon the anatomical changes incident to that lengthening by about one millimetre of the visual axis. Most careful study gives no faintest evidence of fluid in front of the optic nerve. Cases of detachment of the vitreous by exudation in front of the retina at the posterior pole have come to my notice, and were readily recognized and correctly interpreted before I had seen reference to them by others. I am, therefore, as little prepared to admit the presence of fluid here upon this one bit of assumed evidence, as I am to concede the opposing view of Stilling, that there is *always* fluid between the vitreous and the posterior pole, filling a lymph-space which normally exists there (area Martegiani). If there be normally *ante-mortem* a trumpet-shaped cavity in the vitreous body, with its expanded mouth over the optic nerve entrance, ophthalmoscopic evidence of it is wholly wanting—the rare persistence of a visible "Cloquet's canal" being the exception which proves the rule. On the other hand, a glance at the section of the optic entrance in the myopic eye offers an immediate and satisfactory explanation of the phenomenon in question.

In Fig. 2 we have a tracing of one of Weiss's sections of the nerve from a slightly myopic eye (*Mittheilungen aus d. Tübingen Augenklinik*, i., 3, Pl. i.), and in all respects, except the grade of myopia, it closely corresponds to the findings in the case before us. The "drag" of the nerve-head, so generally found in such cases, is very evident, and the distention of the papilla is marked; while the form of the excavation, the prominence of the nasal margin, and the relation of the vessels are well shown. The excessively bent nerve-fibres at the nasal margin form a marked prominence, the most convex portion of which lies a little outside of the nasal margin and forms a surface eminently fitted to give back the crescentic reflection of light with which we here have to do. Close scrutiny of the present case shows no discrepancy between phenomenon and explanation. The reflection, while most marked when out of focus, can still be seen when the summit of the prominence is sharply defined; and this explanation, once considered, seems wholly to supplant any other in the case before us.

While this paper has been awaiting completion, it has seemed wise to renew the search for other instances of the phenomenon, and a series of fifty cases has been studied with scrupulous care. The examination has been made always with the undilated pupil (although often repeated with the dilated pupil), since retinal reflexes, such as the halo around the macula, are always best seen before mydriasis, sometimes wholly disappearing upon dilatation. The individuals have all been young, generally under age; and not a few of them myopic and with distorted disks, where the appearance in question might be expected. Two elder sisters of our patient, presenting similar refraction and eye-grounds, were among those studied with a negative finding. Of the fifty cases, one girl of seventeen, with H. As. (+ 0.50 sph. ⌒ + 0.50 cyl. ax. 50° and 130°) in each eye, showed the curvilinear reflection in its typical form, although there was no measurable prominence of the nasal margin. The common grayish absorbing pigment ring or band to the inner side of the disk,

which Nagel regards as evidence of "supra-traction of the choroid," was quite marked in both eyes. Four other cases presented in one eye a reflex more or less corresponding in form or position to the appearance under discussion, and were demonstrable to others as atypical instances of its occurrence. Four or five others showed shimmering reflexes up and in, too completely lacking any characteristic difference from the reflexes elsewhere visible to be counted as cases in point. Of one hundred eyes, therefore, six only could be said to have presented the curvilinear reflection of Weiss. One other myopic eye, not included in the series, presented a fairly characteristic instance; so I may say that four typical examples of the appearance, and four cases that might be regarded as atypical instances, have come to my notice in the years during which I have sought it.

Small as is the series cited, its negative showing, corroborated by several years of daily experience, convinces me that the "reflex bogen-streif" of Weiss is not present in any notable percentage of cases in this locality, and leads me to doubt the frequency of its occurrence in Germany. Such a statement seems fair, in spite of its recoiling effect—calling into question the skill of the ophthalmoscopist who simply *has not seen;* and comparison of notes with other observers who have seen some instances of the appearance in question, confirms the view as to the rarity of its occurrence.

The theory of Weiss as to its causation appears to be strained. Repeated examination of the phenomenon in the case above reported has wholly failed to furnish the faintest ophthalmoscopic evidence of a collection of fluid in front of the disk. Probably such a collection would become visible only on losing its transparency, as had happened in the cases of detachment of the vitreous which I have seen. Yet some indication ought to be discoverable, if we really have here a detachment of the vitreous. Weiss's claim that the reflecting surface is measurably in advance of the retina (+1 to 4 D.) is not borne out in my limited observation; and upon it rests most of his explanatory theory. In the cases which I have studied, the reflection could be most clearly seen when the retina was out of focus, but could be followed down until the retinal surface was focussed. In this it differed in no wise from the halo around the macula, the crescentic reflection from the *fovea centralis*, or the shimmering "shot-silk" reflexes along the vessels, unless in that it could be *more* clearly seen at the retinal level.

Although Weiss has based his views upon some very important observed facts, there is too much of unproven assumption in his explanation. He starts with the point that all infants are hypermetropic, that older children are less so, and that adults are still less, or have become emmetropic or myopic. Part of this increase in refraction he ascribes to physiological growth—change of curvatures, dimensions, and refractive indices; but part he thinks due to *distention.* In a paper presented at the recent Congress in Heidelberg (*Bericht VII. Internat. Ophth. Congress*, 1888, p. 513), I furnished evidence that this increase in refraction is certainly less than has been claimed, and that "the results must be set down as rather negative, except in wholly failing to support the theory of a physiological progress toward myopia." Cases of distention do occur, as every ophthalmologist of experience has witnessed; and extensive series have been recorded by Risley, Norris (*Trans. Amer. Ophth. Soc.*, 1884, 1885, and 1886), and others. In distending posteriorly, the vitreous chamber becomes enlarged; but it is an assumption quite in opposition to our scanty knowledge of the spongy, bibulous character of the vitreous body, to claim that it is incapable of enlarging to fill the increased area. Loss of vitreous in cataract operations would be of far more serious import were that body destitute of regenerative or expansive character. More extended observation and fuller proof are needed before we can accept the view that in all distending eyes, or in the majority of them, notable collections of fluid must form to occupy the enlarged vitreous chamber. The claim that 38 per cent. of the eyes of school children present a form of detachment of the vitreous will need much modification, or more thorough substantiation, before it will find many supporters.

In conclusion, I desire to ask a careful study of this interesting question, which may have in it much practical importance, although its premises seem as yet insufficient, by all those interested in ophthalmology. The phenomenon described by Weiss undoubtedly exists; and, while striking examples of it are rare and considerable difficulty will be met in recognizing it at first, after it has been once seen its peculiar character will be apparent. I think it not unlikely that I will observe it more frequently in the future than heretofore, and hope at a later time to discuss it more thoroughly.

MEDICAL PROGRESS.

Statistics of Operations on the Gall-bladder.—DR. A. DEPAGE, in the course of a paper upon "Surgical Intervention in Biliary Lithiasis" (*Journ. de Méd. Bruxelles*, 1888, No. 24), says that up to the present there have been 78 cholecystotomies performed. Of these operations, 6 were done according to the method of Spencer Wells, 72 with suture of the gall-bladder to the abdominal wall. Of the first-named series, 3 died from acute peritonitis, 1 cured case was followed by recurrence, and 2 cases were completely cured. Of the second series there were 11 deaths, 5 from hemorrhage and collapse, 2 from biliary retention, 2 from effusion of bile into the peritoneum, and 2 from undetermined cause; there were also 4 deaths from sec-

ondary complications. Amongst the "cures" are 24 cases of biliary fistula, some permanent. The number of cholecystectomies has been 22, with 2 deaths from obstruction of the bile-duct, and 1 after recovery from the operation from a cause independent of biliary lithiasis. Thus, in cholecystotomy with suture of the gall-bladder, and its return free into the abdominal cavity, a mortality of 50 per cent. resulted; in cholecystotomy with suture of the bladder to the parietes, 15.27 per cent.; and in cholecystectomy, 9.99 per cent.; and as the last-named figure comprises the two cases of permanent occlusion of the common bile-duct, the result, if they be excluded, is to enhance greatly the position of cholecystectomy as an operation to be preferred to cholecystotomy.—*Lancet*, Jan. 12, 1889.

A Case of Creolin Poisoning.—DR. CRAMER reports the following: a five year old boy, upon whom he had operated for an inguinal hernia, was ordered applications of gauze saturated with a two per cent. creolin solution, the same antiseptic solution having been used during the operation. Everything went on satisfactorily, no fever set in, the urine continued clear for three days after the operation; in fact, the general condition was excellent. On the evening of the third day, Dr Cramer was called to the patient's bedside to treat, what seemed to the parents, to be scarlet fever. He found the entire body including the face and hands, covered with an exanthem resembling scarlet fever; the little patient appeared extremely restless, complained of great thirst, and of an itching and burning of the skin; temperature was normal, pulse somewhat rapid and small. The urine had a strong carbolic acid odor, as well as the characteristic carbolic acid color.

Dr. Cramer immediately replaced the creolin applications by a three per cent. boric acid solution and administered internally large quantities of seltzer water in order to facilitate the elimination of the creolin through the kidneys. The exanthem lasted until the following morning when it disappeared; but the urine remained dark until the following evening. The boy made a complete recovery.—*Therap. Monatshefte.*

Action of Phenacetin and Sulphonal.—DR. ADOLPHUS OTT, of Prague, in a recent number of the *Prager med. Wochenschrift*, gives some further details as to the effect of phenacetin and sulphonal. With regard to phenacetin as an antipyretic, Professor Ott's experience agreed with that of other investigators. With respect to the drug as an antineuralgic, Professor Ott states that there was hardly any neuralgia, either reflex or peripheral in origin, which could not be influenced by phenacetin. It was only in diseases of the central nervous system, in affections of the brain and the spinal cord that the drug failed in most cases to produce any effect. The best results with phenacetin were obtained in hemicrania and occipital neuralgia. In pure neuralgia of the fifth nerve the effect was only temporary; in one case of severe sciatica, the medicament was useless. In Professor Ott's hands sulphonal proved to be a very good hypnotic. In most cases, tranquil and prolonged sleep supervened after the administration of from one to two grammes. Ott also relates the following interesting observations. On one occasion he had under his care a case of hypochondriasis with arthritic disposition and temporary arhythmia of the heart. The patient, who was accustomed to the injection of morphine, slept well after the administration of two grammes of sulphonal, and the arhythmia always ceased a few minutes after the administration. In another case, however—that of an hysterical girl, aged twenty-nine, who was also accustomed to morphine—no effect could be obtained even with a dose of three grammes. This last observation agreed with Oesterreicher's statement that sulphonal had no effect during abstinence from morphine. It also failed in one case of sciatic neuralgia. The drug was very well borne; no bad after-effects were observed except a sensation of weariness on awaking. In one case of severe chronic catarrh of the stomach combined with nervous irritability and sleeplessness, in which three grammes of sulphonal were given, vomiting and fainting fits occurred. —*British Med. Journal*, Jan. 12, 1889.

For Hysterical Vomiting.—DR. EWALD recommends for this affection the following prescription, of which from ten to fifteen drops are to be taken hourly:

℞.—Hydrochlorate of morphia . .	3 grs.
Hydrochlorate of cocaine . .	5 grs.
Tincture of belladonna . . .	75 minims.
Cherry-laurel water . . .	℥vjss.

—*Revue de Thérapeutique*, Jan. 15, 1889.

A Sulphonal Exanthem.—DR. SCHOTTEN, of Cassel, reports the case of a delicate, nervous woman, forty-five years of age, suffering from chronic myelitis, who for one year had regularly taken chloral on retiring. On the night of August 29th, this patient was given thirty grains of sulphonal; it did not produce sleep, but rather a sense of extreme fatigue. The following evening thirty grains more were administered, with the same effects. On the third evening forty-five grains were administered. This was followed by a prolonged sleep, but on awaking the patient complained of a peculiar feeling of extreme fatigue, manifested by great inclination to sleep, hanging of the head, and difficult motion of the tongue; besides this she complained of headache, of bitter taste, and of loss of appetite. This condition lasted four days, after which time an exanthem made its appearance, beginning on the head and gradually extending over the entire body, resembling in form and color the eruption of measles. The body was hot; the skin had a burning sensation; the mucous membranes were not affected. With the appearance of the eruption, the symptoms of fatigue, etc., gradually disappeared. The exanthem lasted two days, after which it slowly disappeared, leaving traces which were yet noticeable on the fourteenth day.

A sister of this patient was similarly affected after taking antipyrin.—*Wiener med. Presse*, No. 52.

Poisoning by Hydrate of Amylene.—DR. DIETZ (*Deutsche med. Zeitg.*, 1888, No. 24) reports the following: A mixture containing hydrate of amylene was prepared for occasional administration to the patients of a clinic in Leipzig in order to procure sleep. Directions were given to shake the bottle before pouring out the dose. On one occasion the bottle was allowed to stand for a few moments after having been shaken, and then four separate doses for four patients were administered. Amylene hy-

drate being of light specific gravity floats on water, the result being that the dose under these conditions was greatly increased. The symptoms produced in all four of the patients who took the drug were those of acute poisoning by alcohol—prolonged sleep, paralysis of the extremities, abolition of tactile sensibility and of the reflexes, dilatation of the pupils with feeble reaction to light, superficial, irregular respiration, and small, slow pulse. Hypodermatic injections of camphor was the treatment adopted, all the four patients recovering.—*Medical Chronicle*, January, 1889.

Treatment of Eczema.—DR. VEIEL, of Cannstatt (*Med. Corr.-Blatt d. Württ. ärztl. Landesver*, August Heft), writes upon this subject as follows: When treating an eczema, distinction must be made between the acute and chronic form. In the acute form no internal treatment is required, while in the chronic form, arsenic internally, and proper remedial measures externally, are essential. When chlorosis is present, one should administer iron one hour before meals, and arsenic one hour after the same. Scrofulous eczema of children is best treated with cod-liver oil and an appropriate diet combined, if the itching is very annoying, with the internal administration of chloral and bromide of potassium.

In the acute variety, anything that might possibly irritate the skin must be avoided. Children who cannot very well do without their daily bath, should have some slimy substance added to the same. Soap in any form or shape must be avoided. To allay the burning and itching of an acute and dry eczema, Unna recommends the following:

℞.—Oxide of zinc, Gelatine . . . . . āā ʒiv.
Glycerine . . . . . ʒviss.
Water . . . . . ℥iss.—M.

Heat for a few moments, and apply with a camel's-hair brush.

In moist eczema, the affected parts should be thoroughly washed once daily, then dried, and some flour or starch applied. In cases in which this proves of no avail, the author makes use of a pillow filled with powdered starch; the effect is a cooling one, but requires frequent changing. Where the itching is severe, and the starch alone does not give relief, the parts should be powdered with starch to which two per cent. of camphor has been added. Should this still not alleviate the irritation, the parts should be washed with the following:

℞.—Solution of acetate of aluminum . ʒijss.
Water . . . . . ℥iij.
Borax . . . . . 55 grains.
Salicylic acid . . . . . 5 grains.
Water . . . . . ℥vss.
Glycerine . . . . . ʒj.—M.

In the wide-spreading and moist eczema, salves and pastes are of service. Thus, if the eruption has become dry and squamous, a five per cent. tannin salve should be applied. In chronic eczemas the crusts and scales should be detached by bathing, or by applying soft-soap or oil; the addition of one to two per cent. of ichthyol to any of the foregoing will greatly assist their action. If, in spite of this, the scaling should still continue, Lassar's paste, or tar in alcohol, should be applied:

℞.—Liquid tar . . . . . 1 part.
Alcohol . . . . . 3 parts.

This formula is not to be applied to any hairy portion of the body, as it might induce a general sycosis. Should even this last-named remedy prove ineffective, then pyrogallic acid and chrysarobin (in a two to ten per cent. salve) should be tried.—*Therapeutische Monatshefte*, January, 1889.

Some Indications for Pleurotomy.—DR. CARDARELLI (*Il Progresso et La Rasegna di Scien. Med.*, October, 1888) is of the opinion that before performing a pleurotomy, one should first be certain of the existence of the pleuritic exudation, as well as of the quality of the same. To determine this, an exploratory puncture should be made. This done, four conditions remain in which recourse to thoracocentesis is essential: 1st. The presence of an excessive quantity of liquid in the pleura threatening asphyxia. 2d. When the pleural cavity is completely filled, but the patient does not suffer. 3d. When the liquid is purulent, but the patient's condition nevertheless satisfactory. 4th. When there is hydropneumothorax with heart and respiratory trouble due to compression of the vena cava from the pleural exudation.

Two conditions yet remain in which intervention would be justifiable: 1st. In a pleurisy which has been cured, but where a small quantity of liquid still remains. 2d. In an acute pleurisy with high fever, great pain, and rapid formation of the exudation.

In these two last-named conditions the author never hesitates to perform pleurotomy. If a fistula remains, he performs Estlander's operation, but in the majority of cases this even has been found unnecessary.—*L'Union Médicale*, December 27, 1888.

Transfusion in Carbonic-oxide Poisoning.—A workman who had inhaled the vapor of burning coals was taken to the Charite lately. All efforts to restore consciousness having failed, Professor Leyden ordered the injection of two hundred and fifty cubic centimetres of blood, taken from another patient, into one of the veins of the right arm. The patient showed signs of life five hours after the transfusion, then slept for about ten hours, and awoke in excellent spirits. His further recovery was rapid, and he is now quite well.—*Lancet*, January 5, 1889.

Creolin in Ophthalmology.—DR. O. PURTSCHER, of Klagenfurt, gives in the *Centralbl. f. pr. Augenheilk.* his results obtained with creolin in the treatment of diseases of the eye. A one per cent. solution dropped on the conjunctiva of a normal eye produces a sensation of severe burning, which results in the eyelids being closely pressed together. This, however, is only momentary, the lids are soon reopened and large tears flow forth. After three or four minutes the irritation will have subsided entirely, save for a slight conjunctival irritation, which also soon passes off. Hence the author recommends the use of cocaine before the application of creolin.

1st. In simple conjunctivitis, the results, as a rule, were good, especially in congestive catarrh, and in those forms complicated with inflammation of the corneal margin.

2d. In conjunctivitis phlyctenulosa, the combined results of creolin with cocaine were admirable, especially in photophobia and scrofulous blepharospasmus.

3d. Success was most marked in the papillary form of trachoma, the author having never seen such marked resolution of the papillæ from caustic treatment, as from that by creolin.

4th. In blennorrhœa of the lachrymal passages, improvement was observed in many cases.

5th. In all forms of keratitis with ulceration the deep ulcers healed rapidly; also ulcers with small hypopium stood the creolin treatment admirably.

6th. In parenchymatous keratitis the vascular growth was speedily arrested.

The author concludes that creolin is a powerful and valuable antiseptic, and at times to be preferred to the sublimate. It possesses another advantage in being non-poisonous, a fact which has lately been demonstrated by Dr. Eisenberg.—*Centralbl. f. d. ges. Therapie*, January, 1889.

Dropsy of Pregnancy.—Dr. WALTER S. A. GRIFFITH, in an article upon this subject, gives the following advice:

"Treat the patient as a case of acute nephritis with dropsy; if there is no distinct improvement within a reasonable period (from two to four weeks), and with less delay if the dropsy increases, empty the uterus. The best method for doing this is by the introduction of a clean bougie, leaving it in until labor is established; a couple of five-grain doses of quinine being given at the end of twenty-four hours, if the uterus needs further stimulation."—*British Med. Journal*, Jan. 12, 1889.

Relative Value of Opium, Morphine, and Codeine in Diabetes Mellitus.—Dr. THOMAS R. FRASER, in a paper on this subject, concludes as follows: The evidence seems to indicate that codeine is a less powerful remedy in diabetes than either opium or morphine, and to confirm the view that in its therapeutic value it ranks as a weak or diluted morphine.

The conclusion receives an importance (no doubt a subsidiary one) from the circumstance that codeine is about three times as expensive a substance as morphine. The great demand for it has led to its being manufactured from morphine so largely, that probably one-fourth of the codeine in the market is an artificial substance. When we consider the large doses that are required in diabetes mellitus, and the generally protracted duration of this disease, we are, I think justified in asking for more clear evidence of its superiority over morphine than has as yet been produced.—*British Med. Journal*, Jan. 19, 1889.

Common Salt in Nervous Affections of the Stomach.—Dr. BATROM has lately employed common cooking salt in the treatment of migraine, and Dr. NOTHNAGEL has recommended the same in the treatment of epilepsy. Dr. CERNÉ attributes his success in the treatment of the first affection with this remedy, to an increase of the hydrochloric acid of the gastric juice. In a case of gastralgia and migraine, in which the treatment simply consisted in augmenting the quantity of salt in the food, he noticed that the dyspeptic symptoms and stomachal pains disappeared entirely.—*La Normandie médicale. Revue Thérapeutique*, December 15, 1888.

Atrophic Coryza.—Dr. E. J. MOURE (*Journal of Laryngology and Rhinology*, November, 1888), after going very fully into the etiology and pathology of this condition, lays down the following rules for treatment:

A first irrigation of the nostrils made with one or two litres of tepid sulphurous water, to which is added either chlorate of potash, bicarbonate of soda, or borax, in the proportion of a teaspoonful to the litre. This is followed by a second irrigation, consisting of half a litre of tepid water, with the addition of a tablespoonful of the following fluid:

Carbolic acid	20 parts.
Glycerine	100 "
Alcohol at 90°	50 "
Water	350 "

In order that the patient may not get accustomed to this solution, he substitutes chloral, resorcin, salicylic acid, etc., for the carbolic acid every month. After the douches, the patient ends the treatment by spraying the nostrils or insufflation of fine powder. For spraying he uses:

Carbolic acid	2 parts.
Resorcin (crystals)	3 "
Glycerine	50 "
Water	300 "

or

Camphor	8 parts.
Tinct. iodi.	10 "
Tar	12 "
Alcohol at 90°	100 "
Water	200 "

To be warmed, and used to moisten the nose for one or two minutes after spraying.

Nasal douches must be carefully directed toward the naso-pharynx, and not up toward the root of the nose. They should be used tepid, and in small stream.

Thymol, Moure does not like, as it is painful, and not certain in its action. Surgical treatment he entirely discards, and Gottstein's tampons he has not found valuable, and very inconvenient.—*Bristol Medico-Chirurgical Journal*, Dec. 1888.

The Treatment of Scarlet Fever by Mercuric Iodide.—Dr. PURDY, at a meeting of Leeds and West-Riding Medico-chirurgical Society, referred to Dr. Illingsworth's original paper recommending this treatment and the support given to it by Dr. Clement Dukes, of Rugby. He stated that he had tried it in more than fifty cases, during several epidemics, and was surprised at the results. In spite of the disease in one epidemic being of very severe character, there was only one fatal case, and that was dying when first seen. After giving the drug the temperature fell rapidly, and the patient seemed well in about three days, desquamation being very slight. The average period during which his cases were isolated was only eighteen days. He had seen no cases of infection from convalescents, and there were no lingering sequelæ. In one case a child was ill for five days, the diagnosis being uncertain; then the mother and several children sickened with evident scarlatina, two being very ill, with sloughs in the neck, but all made a good recovery, and were perfectly well before the first child had ceased peeling. The formula used was liq. hydr. perchlor. ℥j, pot. iodid. ℥ss, syrup.

ad ℥viij. Half an ounce to be taken every one, two, or three hours, according to circumstances. Several of his friends had tried this treatment but with less good results, owing, he believed, to the treatment not having been begun early enough, or the doses being insufficient.

MR. HICK said that he had treated in the Leeds Fever Hospital fifty cases with mercuric iodide. Except that there were more cases of nephritis than usual, he could detect no special effect from the use of the drug. He had treated recently three series of eight cases each simultaneously, with iron, mercuric chloride, and a *placebo*, and, on the whole, the latter series did best. He had tried the treatment also in typhus, typhoid, and small-pox, but with no result.—*British Med. Journal*, Jan. 19, 1889.

Suppositories for Cystitis.—

℞.—Iodoform . . . . 1¾ grains.
Extract of hyoscyamus . . 1 grain.
Cocoa-butter . . . . 45 grains.—M.

Make one suppository and introduce high up into the rectum.

The bladder should be washed morning and evening with lukewarm water. If there be any urethral irritation, a pill containing 1¾ grains of terpin should also be taken morning and evening.—*Journal de Médecine*, January 6, 1889.

Strophanthus in Pneumonia with Threatened Heart Failure.—DR. GRATZ (*Centralbl. f. klin. Med.*, No. 45, 1888, and *Münch. med. Wochenschrift*, p. 125, 1888) says, that at the Policlinik, at Erlangen, Dr. Pentzold has employed strophanthus in fifteen cases of severe pneumonia, with symptoms indicating heart failure. He gave the five per cent. tincture, in doses of ten drops, three times daily, and with very satisfactory results, as shown by an improvement in the general condition, slight decrease of the breath and pulse frequency, and especially a decrease in the irregularity of the heart's action. No unpleasant effects from the drug were observed.—*Medical Chronicle*, January, 1889.

Parenchymatous Injections of Distilled Water in the Treatment of Chronic Tumors of the Spleen.—DRS. MURRI and BOARI, being convinced that the benefit derived from arsenic injections in the treatment of tumors of the spleen is not due to the arsenic, but rather to the fluid injected, treated a case of splenic tumor, in a man of twenty, suffering from chronic malaria, by daily injections of one Pravaz-syringeful of distilled water into the parenchyma of the spleen. After two months of this treatment, the organ was considerably reduced in size. Drs. Murri and Boari recommend this treatment highly, which, if carried out carefully, is not followed by evil consequences.—*Wiener med. Presse*, Jan. 13, 1889.

Treatment of Acute Diffuse External Otitis.—DRS. MIOT and BARATOUX prescribe, when the secretion is excessive, the following injections:

℞.—Bicarbonate of sodium . . 5 parts.
Water . . . . . 1000 "

or

℞.—Boric acid . . . . . 1 part.
Water . . . . . 35 parts.

or

℞.—Bichloride of mercury . . . 1 part.
Water . . . . . 200 parts.

—*Revue Gén. de Clinique et de Thérapeutique*, January 16, 1889.

Treatment of Pruritus of the Vulva.—If the affection is an acute one, a lotion containing a small quantity of bromide of potassium or chloral is of use. It is preferable to have the lotion warm rather than cold.

When the acute stage has passed, the following lotion should be applied:

℞.—Water . . . . . 300 parts.
Sublimate . . . . . 1 part.
Alcohol . . . . . q.s.

In chronic cases Dr. Guéneau de Mussy prescribes the following ointment, to be applied to the vulva two or three times daily:

℞.—Glyceride of starch . . . ℥v.
Bromide of potassium . . . 15 grains.
Subnitrate of bismuth . . . 15 "
Calomel . . . . . 6 "
Extract of belladonna . . . 3 "

or

℞.—Infusion of mallow . . . 1000 parts.
Cherry-laurel water . . . 50 "
Borate of sodium . . . 10 "

This lotion to be followed by the application of the following powder:

℞.—Powdered lycopodium . . . 30 parts.
Subnitrate of bismuth . . . 10 "
Belladonna-root . . . . 2 "

The following ointment is also of service:

℞.—Diachylon ointment } . . . equal parts.
Olive oil }

For an eczema of the vulva, Dr. Lusk recommends the following lotion:

℞.—Bicarbonate of sodium . . 8 parts.
Bicarbonate of potassium . . 4 "
Glycerin . . . . . 6 "
Tincture of opium . . . 8 "
Water . . . . . 250 "

Applications of a solution containing cocaine might also be tried:

℞.—Glycerine . . . . . ℥vjss.
Cocaine . . . . . 15 grains.
Chlorhydrate of morphia . . 1¼ "

In very obstinate cases Dr. Martineau employs sublimate baths; made by adding the following solution to a bath:

℞.—Water . . . . . 190 parts.
Sublimate . . . . . 20 "
Alcohol . . . . . q.s.

While these local applications may all be of service, one must not omit constitutional treatment which often relieves indirectly the cause of the pruritus.—*Revue Générale de Clinique et de Thérapeutique*, Jan. 16, 1889.

Decussation of Fibres of Voluntary Movement.—DR. BROWN-SÉQUARD in an exhaustive paper upon this subject reaches the following conclusions:

1st. The fibres of the anterior pyramids which cross and overlap each other at the inferior portion of the bulb, can be the only, or at least the principal, channel for the transmission of voluntary motion.

2d. The protuberance, as supposed by a number of physiologists, must be the principal point of decussation of the fibres which control the voluntary movements of any member.

3d. The decussations of the fibres for voluntary as well as for reflex motion of the limbs are found along the entire length of the cerebro-spinal centre.

4th. It is wrong to assume that paralysis due to unilateral lesions of the bulb or other parts of the encephalum, in man as well as in animals, depends upon the destruction of localized centres or upon groups of fibres serving only for voluntary motions.—*Archives de Physiologie*, January, 1889.

Male Sterility and Gynecology.— DR. FÜRBRINGER, of Berlin, has written some important observations on this subject in the *Deutsche Med. Wochenschrift*, No. 28, 1888. He believes that sterility in the male is far more frequently the cause of barren marriage than is generally believed to be the case. Aspermatismus is associated with complete impotence, but azoöspermia, or absence of spermatozoa in the semen, a condition by no means rare, may exist with perfect potency, and on that account is very easily overlooked. With few exceptions, azoöspermia is caused by obliteration of part of the seminal ducts. This condition is generally caused by double gonorrhœal epididymitis, or inflammation of the vas. After that malady, the chances are, Dr. Fürbringer has calculated, nine to one that azoöspermia will follow. Prognosis appears to be hopeless when the condition in question is not discovered until three or four months after the onset of the local inflammation. The chief importance of the management of the case lies in accurate diagnosis. True aspermatism is traced by Dr. Fürbringer to arrested development of the ejaculatory ducts. He declares that in several cases of sterile marriages under his own observation the unfortunate wife had been sent from physician to physician, or from hospital to hospital, and her cervix divided, or her endometrium scraped, until a glance at the microscope proved that nothing was wanting to insure the blessing of children, excepting spermatozoa. Dr. Fürbringer's observations are worthy of consideration. No doubt the increase of temperance involves the relatively greater frequency of those forms of gonorrhœa where the earlier symptoms are very mild. Hence the first stages may now be as much neglected by patients as they have ever been wont to neglect later stages. The more a case of gonorrhœa is neglected, the greater will be the chance of serious secondary complications.—*British Med. Journal*, Jan. 19, 1889.

Treatment of Typhoid Fever with Naphthol.—DR. GENNARO PETTERUTI gives in the *Giornals internaz delle scienze medische*, No. 10, his results obtained with naphthol in the treatment of typhoid fever. From his observations he concludes that naphthol may be administered in doses up to sixty grains daily. The only unfavorable symptoms observed during its administration were a more or less severe burning sensation felt while urinating, and a dark brown coloring of the urine. This discoloration of the urine begins five hours after the remedy has been taken and lasts throughout the treatment, and is, no doubt, due to the absorption of a certain quantity of naphthol from the intestines, which finds its way into the urine. Diarrhœa was rarely observed.

Not only does naphthol possess an antipyretic action like antipyrin, thallin and other antipyretics, but it also has a direct healing influence upon typhoid fever. In the author's cases a reduction of temperature followed the administration of naphthol, which did not rise again even after the remedy was withheld. The fall in temperature which begins between the second and third day continues till it has reached the normal.

The advantage of naphthol over other antipyretics consists in its being well borne by the intestinal mucous membrane and in being absorbed in small quantities only by the intestinal canal, thus remaining for a longer time in contact with the affected parts.

With children under four years of age, the author began treatment with daily doses of fifteen grains, which was at no time allowed to exceed thirty grains, while adults for the first few days were given four doses of eight grains each, and later on eight doses daily of the same quantity, the interval between each dose being one hour.—*Wiener med. Presse*, January 6, 1889.

Creolin as an Antiseptic.—DR. L. A. STIMSON, at a recent meeting of the New York Surgical Society, showed a sample of pure creolin, and also one of a two per cent. mixture in water. It was a dark, viscid liquid with a tarry odor, insoluble except in alcohol, a two per cent. aqueous mixture appearing as a fine emulsion. He had been much troubled by the fact that secretions from wounds readily underwent decomposition under dressings of sublimate gauze, and had thus been led to try creolin. He had now employed it for two months at the New York and Chambers' Street Hospitals, with very satisfactory results, using ordinary purified gauze wrung out in a two per cent. aqueous mixture. The drug was rarely irritating to the skin. It was not only a good antiseptic, but it also arrested parenchymatous bleeding and hastened cicatrization. When applied to ulcerated cancerous surfaces, it was a powerful deodorizer. Chemically it closely resembled a cheap patented disinfectant, sold under the name of "soluble phenyl," but the latter was of somewhat thinner consistence; creolin contained no carbolic acid.—*New York Medical Journal*, Feb. 2, 1889.

Poisoning with Hydrochloric Acid.—DR. MAURICE LETULLE and HENRY VAQUEZ from numerous observations on persons poisoned with hydrochloric acid, made during life and at post-mortem, reach the following conclusions:

1st. Hydrochloric acid in poisonous quantities produces severe gastritis with embryonic proliferation and extensive cellular necrobiosis.

2d. Experience and clinical observation prove the frequency and danger of penetration of the caustic liquid into the respiratory passages, during the efforts at regurgitation or vomiting which follow the ingestion of the poison.

3d. Hence these efforts at vomiting, should be, if possible, prevented and counteracted by promptly washing out the stomach with appropriate solutions.—*Archives de Physiologie*, January, 1889.

THE MEDICAL NEWS.

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SATURDAY, FEBRUARY 9, 1889.

PUNCTURE OF THE ABDOMEN FOR EXCESSIVE TYMPANITES.

THAT it is most desirable and expedient to relieve distressing or dangerous tympanites all will agree, but the same unanimity of opinion will not prevail when we come to consider by what means this shall be accomplished. Of surgical methods there are two: the rectal and œsophageal tubes, and puncture or aspiration of the intestines or stomach through the abdominal parietes. These latter procedures have recently been most elaborately set forth and heartily commended in a valuable historical and clinical monograph from the pen of Dr. John W. Ogle, of London. In this work the author has collected from the experience of his hosts of friends and colleagues a vast array of cases and clinical material. Perusing the mass of facts therein contained we find that, as a rule, surgeons are not zealous in advocacy of the measure whilst medical men, including Ogle himself, are almost all pronounced in its favor. We, ourselves, have had small but salutary experience with the operation, and, whilst acknowledging our previous dislike to it upon theoretical principles and hearsay of a few instances in which unfortunate consequences were said to have followed its employment, must, in the absence of larger personal experience, yield to the greater weight of contrary evidence presented by Ogle, and agree that, properly performed in judiciously selected cases, the operation of puncture of the abdomen for tympanites is comparatively safe and expedient. As an euthanasic measure it is always justifiable.

From Ogle's work we cull many of the following facts regarding the range of application and mode of performing the operation. Puncture will effectively relieve distention of the colon and stomach, and some cases of small intestine inflation if the calibre of the latter is greatly enlarged; otherwise tapping the small bowel will usually prove unavailing, because of its numerous kinks and twists. The stomach should only be punctured when obstruction of the œsophagus prevents its relief by the tube. Incurable cases of bowel obstruction are robbed of some of their most distressing symptoms by puncture; whilst cases of curable obstruction are much more apt to be spontaneously reduced after the distended bowel and impeded heart and lungs have been relieved by aspiration of the intestines. Drugs likewise, when before unabsorbed and powerless, will often be taken up and begin to act copiously upon the intestines so soon as distention is relieved.

To perform the operation, the abdomen should first be made technically clean by the use of soap and antiseptics. Then into the most prominent coil of bowel presenting, a trocar is plunged until it enters the lumen, when a rush of gas will take place through it. The trocar should be the very smallest available, and not triangular or spear-pointed, but round, that bloodvessels shall not be wounded and that the intestinal mucous membrane shall most effectively close the opening in the bowel thereby made. The aspirator jar is by no means necessary, for in most cases the gas will be rapidly forced out by the intra-abdominal pressure. When all gas has been discharged that will flow out, a little water is injected through the trocar to cleanse it, and it is then withdrawn by a quick motion; and the minute abdominal wound immediately sealed with such a dressing as iodoform and collodion. If large-sized trocars are employed, there is great danger of fecal extravasation, either at once or when distention recurs. Several or many punctures at various points over the distended bowels may be necessary for entire relief, and repetition of the operation may be required to remove re-accumulations due either to formation of more gas in the colon or to its advent from the small intestine. The puncturing instrument must be thoroughly cleansed between punctures, by boiling, if more than one is required.

According to Ogle's large collection of cases, extravasation after such puncture practically never

occurs nor do adhesions form, subsequent operation becomes more dangerous or unpromising, or other noxious effects follow.

We recall a case which was suffering from impaction of a great number of the bones of pig's feet in the lower colon, in which all purgatives and clysters had refused to act, and the distress and cardiac danger were so great that we felt compelled to insert hypodermatic needles into various points along the course of the immensely distended colon. Gas rushed through these for about fifteen minutes, when the colon had become entirely collapsed. Within a very short time the accumulated purgatives began to act vigorously and the mass of obstructive material was soon dislodged, and passed by rectum. No untoward results followed and the patient was almost immediately cured.

THE SEPARATION OF THE SICK FROM THE INDIGENT POOR.

ACTING in accordance with the principles which have governed the growth and development of the great hospitals of the world, to which THE NEWS drew attention in its issue of January 12th, the authorities of Philadelphia are about to remove their indigent poor, not hospital patients, to a suitable almshouse, thus affording the city hospital much needed additional space.

The advantages of applying the funds of a city appropriated for the care of the sick to them only, and reserving for chronically disabled pensioners a style of maintenance adapted to their condition, have been demonstrated in European cities and in some American institutions. From the standpoint of medical science such a policy results in placing the largest available clinical material under the observation of the profession, in securing for hospital patients the best professional skill, and in advancing the cause of medical education.

The Philadelphia Hospital is probably the oldest on this continent, and affords a large field for clinical study. It is a curious fact that many of the oldest hospitals of the world exhibit the lowest death-rate, and are the scene of the greatest achievements of medicine and surgery. With the present knowledge regarding infective agents and the means for destroying them, large hospitals are as safe as the isolated dwelling, and when the systematic care and skilled treatment which they afford are considered they are more favorable fields for medical science than the dwelling.

American cities should adopt universally the principle of discrimination in the expenditure of public funds for the indigent; the sick should receive the most skilful and scientific treatment available, and afford opportunities for clinical study; the chronic pensioner should be maintained in the neighborhood of a city, and his labor utilized if possible. In this manner the public hospitals of the country will best further the interests of the State and the profession.

DR. HOLMES'S GIFT.

WE mentioned in last week's issue of THE MEDICAL NEWS the fact that Dr. Oliver Wendell Holmes had given his medical library to the Boston Medical Library Association. The oldest book of this collection of a lifetime was written in 1490, and the latest in 1887. In parting with these old companions, Dr. Holmes does so with a grace that marks everything that he puts his hand to.

"These books," says he, "are dear to me; a twig from some one of my nerves runs to every one of them, and they mark the progress of my study and the stepping-stones of my professional life. If any of them can be to others as they have been to me, I am willing to part with them, even if they are such old and beloved comrades." Bearing in mind that these are medical books chiefly of which Dr. Holmes is speaking, his warm praises become an encouragement to publishers to put forth the best, and only the best, books on the healing art.

Another reflection, a little tinged with sadness, is in the likeness in this act to that of a tired workman putting away his tools. Dr. Holmes is rapidly approaching his eightieth birthday, and these books of his are no longer needed in the period of retirement for which he is preparing to spend the remnant of his days.

While it cannot be said that the best of Dr. Holmes's intellect has been given to medicine, he has always been so loyal to her interests and so prompt in her support, that she has no feeling of jealousy to gratify because of the immortal honors he has won in other fields, and we believe that no class of readers of Dr. Holmes's works of wit and fiction has been better fitted for the enjoyment of them than have been his foster-brethren of the healing guild. Long may his years be in the land, and full of honor and free from all physical ill.

LAST Tuesday, the Trustees of the University of Pennsylvania filled the vacant chairs in the Medical

Department by the election of Dr. J. William White to the Professorship of Clinical Surgery, and Dr. John Guitéras to that of Pathology and Morbid Anatomy.

Dr. Guitéras is a native of Cuba, where he received his preliminary education, graduating from the Medical School of the University, in 1873. In 1879 he was appointed by the President of the United States a member of the Havana Yellow Fever Commission, and took charge of the investigations in morbid anatomy. In 1880 he was appointed to the Marine-Hospital Service. He was ordered by the Government to investigate epidemics of yellow fever in Vera Cruz, 1883; Key West, 1887; and Florida, 1888. Dr. Guitéras has lectured in various medical colleges, and has made valuable contributions to medical science. In order to accept the Chair of Pathology, he will resign his commission as Passed Assistant-Surgeon of the United States Marine-Hospital Service.

Dr. White was born in Philadelphia, and graduated in Medicine at the University in 1871. He is surgeon to the Philadelphia, German, and the University Hospitals, and has been a frequent contributor to the medical journals. He was the first Director of Physical Education in the University, and was largely instrumental in placing this department on a scientific foundation. Dr. White was also prominent in the work of introducing training schools for nurses in the University and Philadelphia Hospitals.

THE Trustees of the Johns Hopkins Hospital have decided to formally open the Hospital on the first of May, and they have confided its organization to President Gilman, of the University. We understand that for one year, at least, President Gilman will reside in the Hospital, and exercise a close personal supervision over its executive management.

GREAT credit is due to the physicians who resisted pressure from high sources and declined to certify falsely as to the cause of death of the Archduke Rudolph. Professor Hoffmann, in addressing the University students last Monday, said that whatever rumors might be circulated, and whatever assertions might be made, he could declare, with a clear conscience, that he and his colleagues, in their report of the autopsy on the Crown Prince, signed nothing but what they could answer for with their honor.

REVIEWS.

CLINICAL LECTURES ON CERTAIN DISEASES OF THE NERVOUS SYSTEM. By J. M. CHARCOT, M.D. Detroit: George S. Davis, 1889.

WITH the exception of Claude Bernard and Brown-Séquard, the name of Charcot shines, and has shone for years, par excellence, as the best exponent of medical thought in France. Even yet, in his early old age, this greatest of neurologists, still gives, and we hope will continue to give, practical lessons to the profession, which are generally far more wide-reaching in their bearings than is often thought. As a consequence, every one is glad to hail a translation of Charcot's lectures or books, and always finds on their pages much food for thought.

In this little book the subjects of spiritism (*sic*) and hysteria, and the treatment of the latter by isolation, choreiform movements and tremblings, and rhythmical chorea, are carefully considered in the first three chapters; while in Chapters IV., V., VI., VII., and VIII, the study of muscular atrophy resulting from articular lesions, contractions of traumatic origin, painless tic of the face, muscular atrophy from articular rheumatism, and hysteria in the male are likewise brought vividly before the reader. The book is made the more interesting by the insertion of a short biography of Charcot by the translator, Dr. Hurd, and this alone is worth the cost of the volume, showing, as it does, not only the character of the man and the breadth of his thought and labors, but, in addition, the fact that by diligence and thought he has reached a plane of professional favor and esteem on which few other medical men can stand, and which may well serve as an example to those who value the goodwill and admiration of their fellows.

PULMONARY CONSUMPTION CONSIDERED AS A NEUROSIS. By THOMAS J. MAYS, M.D., Professor of Diseases of the Chest in the Philadelphia Polyclinic. Pamphlet, 8vo. pp. 63. Detroit: George S. Davis, 1888.

THIS brochure consists of two lectures, which were delivered at the Philadelphia Polyclinic in the course of 1888–89. The author holds that in consumption the lung affection is only "a special manifestation of the disease which invades the whole body; and that all its diversified symptoms, such as fatigue and exhaustion, anorexia, dyspepsia, wasting, dyspnœa, sweating, diarrhœa, hæmoptysis, intercostal tenderness, hoarseness, aphonia, and œdema, are not the consequences of pulmonary disease, as is commonly believed, but in all probability find a common bond of union in a general disorder of the peripheral nervous system.

"That it is possible for a neurosis of the vagus to give rise to all the lesions which are generally found in phthisical lungs, is not beyond the bounds of legitimate reasoning, although it may not be demonstrable by experiment. For it has already been shown, as in the case of herpes zoster, that disturbed innervation is capable of leading to a catarrhal inflammation of the skin, and if a herpes or a catarrhal inflammation can be produced in the skin through nervous influence, it is also within the limits of logic to hold that the same may occur in a mucous membrane,—the morphological counterpart of the skin. And, after the catarrhal con-

dition is once permanently established in the bronchial tubes and in the air-cells, all the other pathological changes which are characteristic of phthisis follow as a necessary consequence. A catarrhal process in these surfaces implies a proliferation of epithelial cells, and, on account of the sacculated form of the alveoli, the catarrhal material, unlike on the free skin surface, where it may be removed as soon as it forms, is very liable to accumulate in and pack these structures and form small nodules, which are commonly, but erroneously, called tubercles. These smaller nodules coalesce and form larger masses, which finally impinge on the surrounding circulation, and thus cut off their own nutritive supply. After this takes place they undergo a cheesy degeneration, soften, communicate with a bronchus, are expelled, and leave a cavity behind."

As to treatment, the author holds that rest, absolute or an approach to it, is one of the most vital factors in the successful treatment of serious nervous disease, and he believes that "the prevailing opinions that consumptives must have plenty of exercise and fresh air are two of the greatest stumbling-blocks in the successful management of this disease."

OSTEOTOMY FOR ANTERIOR CURVATURES OF THE LEG. By DE FOREST WILLARD, M.D., Lecturer on Orthopædic Surgery, University of Pennsylvania. Pamphlet, 8vo. pp. 20.

THIS paper was read before the American Orthopædic Association at its meeting last autumn. Its author's views are summarized in the following conclusions:

1. Anterior tibial curves during the soft and springy stages may be corrected by manual rectification and the use of apparatus.

2. Braces are useless after hardening has occurred.

3. Manual fracture is the best and safest remedial operation in young children.

4. Instrumental fracture, or osteoclasis, is not as safe or effective as osteotomy.

5. Aseptic simple osteotomy for all moderate degrees of curve, and cuneiform section for very severe grades, give almost uniformly good and speedy results, without suppuration. Subcutaneous section by the saw is also a reliable operation.

6. Plaster of Paris is the simplest and most effective material for securing accurate position and maintaining absolute fixation. By its use the delay and injury incident to suturing the ends of the bones are avoided.

SOCIETY PROCEEDINGS.

NEW YORK ACADEMY OF MEDICINE.

SECTION IN OBSTETRICS AND GYNECOLOGY.

JOSEPH E. JANVRIN, M.D., CHAIRMAN.

Stated Meeting, January 24, 1889.

DR. H. J. BOLDT read a paper on

THE TREATMENT OF SUPPURATIVE DISEASE OF THE UTERINE APPENDAGES.

At the present time, he said, there was much difference of opinion in regard to the justifiability of surgical interference in diseases traced to the uterine appendages, and while some gynecologists had gone to extremes in operating, others had gone to extremes in the opposite direction, instead of keeping the medium and selecting cases for operation with great care. Cases of disease of the uterine annexa might be roughly divided into three groups: 1. Those in which an operation is altogether unjustifiable. 2. Those in which it is the wiser course to keep the patient under treatment for a time, in order to observe what benefit may thus be derived, before deciding finally as to the advisability of operating; and 3. Those in which delay is not only unadvisable, but actually fraught with danger.

His special object was to argue the necessity of abdominal surgery, as a rule, in the disease of the Fallopian tubes known as pyosalpinx; excluding certain exceptional cases to be noted hereafter. This plea for operative interference was based upon a number of cases coming under his own observation, and the histories of which he then proceeded to narrate.

CASE I.—April 15, 1887. Theodora K., thirty-six years of age. Married sixteen years; one child, born fourteen years ago. Labor was instrumental, and followed by metritis and peritonitis. Her illness dates back to this confinement. During the last five years, her pains have increased, and she has had a number of attacks of local peritonitis. Five years ago she was infected by her husband with syphilis, from the secondary effects of which she is still suffering; and the increase of the pains thus corresponds with the syphilitic poisoning. Having described the symptoms and the physical signs, he said that the diagnosis made was double salpingo-oöphoritis syphilitica with endometritis, and an operation was advised if improvement did not result from a few months' treatment. On May 15th a fresh attack of pelvic peritonitis occurred as the result of violent physical exertion. On May 20th he was summoned to the patient, who was suffering intense pain, and found her then with a general peritonitis. At this time the tubes, which could formerly be distinctly mapped out by the fingers, had lost their contour, and in the position occupied by them a general fulness was found; while the examination caused excessive pain. It was therefore apparent that the tubes, which had been distended with pus, had ruptured, and a general peritonitis had thus been excited. The patient was removed to the hospital on the same day, but, unfortunately, he did not make up his mind to operate until the following afternoon, when an experienced colleague concurred in the diagnosis and the course to be pursued. At 9 P. M., he performed abdominal section, when the diagnosis made was confirmed. The abdomen was thoroughly washed out, and a Sims's drainage tube placed behind the uterus, washings being made afterward at frequent intervals. For thirty-six hours the patient did well, but she then began to sink, and sixty hours after the operation died in collapse.

CASE II.—Kate L., aged twenty-nine, single, non-pregnant, seen in consultation May 25, 1887. She gave the history common to cases of salpingitis previous to her present illness. On April 21st she was suddenly seized with severe pain in the lower part of the abdomen, which gradually increased in intensity for some time, and then began to subside. On May 23d she again became worse, and developed a high temperature. On examination it

was found that she had general peritonitis and was much emaciated. The seat of the most intense pain was to the right of the uterus, where a fulness with slight fluctuation was appreciable. The diagnosis was septic peritonitis from the rupture of the right Fallopian tube, in which pyo-salpingitis had previously existed; and this was confirmed when laparotomy was performed at the hospital on the following day. The abdominal cavity was thoroughly cleansed of pus, but the hemorrhage was so profuse from the points where the adhesions were separated that no attempt was made to introduce a drainage-tube, and the patient's condition was so poor that time could not be spared to look up and secure all the bleeding points. Instead, that part of the pelvis from which the hemorrhage came was tamponed with iodoform gauze. The peritoneum was separately closed, as in all Dr. Boldt's abdominal sections, with the exception of the lower angle where the tube protrudes, when the latter is used. The patient rallied remarkably well, the iodoform gauze tampon acting admirably as a drain and as a hæmostatic. Thirty-six hours afterward it was removed, and a hard-rubber double current drainage tube, through which the abdominal cavity was washed out, inserted in its place. Later she began to sink and on the fifth day she died. The autopsy showed diffuse nephritis, but the pelvis was perfectly clean, and there was found to be a decided diminution of the peritonitis.

CASE III. was that of a young woman twenty-three years of age, who had been married eighteen months, and had a child six months before she came under observation. The diagnosis was endometritis and double pyosalpinx of puerperal origin. Both tubes were felt enlarged, and the right ovary was about the size of an English walnut. The uterus was displaced anteriorly and was very tender, and the cervix was lacerated bilaterally. On June 12th he was suddenly summoned to see the patient, who had been seized early in the morning with a very severe attack of abdominal pain, accompanied with vomiting. She was suffering from slight shock and there was marked tenderness over the entire abdomen, but no evidence of intense general peritonitis. The enlarged tube could be no longer felt on the right side, and the diagnosis of rupture of a pyosalpinx was made. Within two hours after first seeing the patient he opened the abdomen, and the diagnosis was confirmed. Peritonitis had already begun, but after thoroughly cleansing the abdominal cavity he closed the wound, using no drainage; and the patient made an uninterrupted recovery.

CASE IV. was also that of a young woman with double pyosalpinx of puerperal origin. Operation was advised but the patient did not consent. On July 27th she was attacked with intense abdominal pain and tympanites, and the diagnosis of commencing peritonitis from rupture of one or both tubes was made. Abdominal section was promptly performed, the cavity thoroughly cleansed, and the wound closed. Although the peritonitis had made considerable progress for such a short time, the patient made a complete and rapid recovery. In this instance one tube had ruptured, causing the attack, and the other became ruptured during removal.

In commenting on these cases Dr. Boldt expressed great regret at not having operated earlier on the first case, and stated that twice within the past two years he had seen cases on the post-mortem table which had died of purulent peritonitis directly attributed to a ruptured pyosalpinx. These cases he also related: The first came to his clinic in March of last year, and he at that time advised opening of the abdomen and removal of the uterine appendages. On June 30th he was summoned to the patient's house, where he found her suffering from general peritonitis. The immediate operation was declined, and she died July 2d. In the second case the patient also developed general peritonitis, but recovered without an operation. His prognosis was guarded, however, as the tubes continued to enlarge after this. Subsequently she had a very sudden and sharp attack of pain in the right inguinal region, and when he reached the bedside he found her in agony, screaming with pain, cyanotic, and with a high temperature and feeble, frequent pulse. The diagnosis of rupture of the right tube was made, but as the patient rapidly improved under opiate treatment while the preparations were being made to operate, and it, therefore, seemed possible that an error had been made in diagnosis, it was decided, on consultation, to defer the operation at least to daylight. In two hours, however, she began to sink, and by morning operation was entirely out of the question, despite the free use of stimulants.

His conclusion was, that abdominal section cannot be too strongly urged in every case of active pyosalpingitis, from whatever cause it may arise, except in the rare instances where the uterine extremity of the tube is patent, so that pus can be squeezed out of the latter into the uterus; and excepting also those cases where the tubal disease is complicated with another disease which itself will probably destroy life in a short time.

As to the question of diagnosis, he thought that a careful observer, experienced in this line of work, would not often make a mistake. The conditions from which it was usually necessary to differentiate were hydro- and hæmato-salpinx; but if the tubes were much distended the question of ovarian or par-ovarian cyst had also to be taken into consideration. The history of the case was of the greatest importance in determining its true nature. While many gynecologists considered it unjustifiable to operate for hydro- or hæmato-salpinx, it was unfortunately an impossibility always to make the positive diagnosis before opening the abdomen; and, furthermore, he still adhered to the opinion, expressed by him two or three years ago, that even cases of hydro-salpinx should be operated on if they give rise to serious morbid symptoms which cannot be alleviated by other treatment, because the simple and inert liquid may take on purulent changes as the result of an inflammatory condition set up in the walls of the tube, or the extension of endometritis. It was also a fact that, in consequence of their openings being blocked, the tubes might become distended to such an extent as to cause rupture with the possibility of fatal peritonitis resulting. He desired to lay special stress on the point that when we have reason to suspect active suppurative disease we should open the abdomen, from which, even if our diagnosis should prove wrong, not much harm would result to the patient.

If the diagnosis of pyosalpinx was correct, immense advantage was conferred upon the woman, since, in the first place, the operation, as a rule, removed the pain incident to the condition, and changed her from an invalid to a healthy individual; and, secondly, removed the danger of rupture of the tube and fatal peritonitis.

It was true that at the meeting of the American Gynecological Society in 1887 a prominent German operator had said that his mortality from salpingo-oöphorectomies was over twelve per cent., and that in his last published statistics this percentage was even somewhat higher; but it was to be borne in mind that the cases selected by him for operation were extremely unfavorable, since he waited very long and exhausted all other means of treatment before resorting to it. It was against this very long waiting that he would protest. Why let a patient suffer so long when from the history and the physical examination we are satisfied ourselves that she is suffering from a condition not amenable to non-surgical methods of treatment?

If in any case when pyosalpinx was supposed to exist, and laparotomy having been performed, it was found that hydro- or hæmato-salpinx was present, Dr. Boldt was very positive that the tube should be removed, notwithstanding the fact that it did not at the time of the operation contain pus, provided it was at some point firmly excluded from the effects of adhesive inflammation. In some comments on the second case included in the paper he said that, admitting that home care among the poorer classes was very much inferior to hospital nursing, he should not again expose a patient suffering from general peritonitis to the danger of removal to a hospital (which in this instance was four miles from the woman's residence), but take his chances of watching the case at home. The patient's condition being so very low, it was of paramount importance to operate as quickly and with the loss of as little blood as possible, and in this case the iodoform gauze, advocated principally in Germany, was used with much success; the many bleeding points and the broken-down condition of the tissues rendering it impossible to apply successfully ligatures or the hæmostatic process. Since that case he had several times had occasion to observe the efficiency of the gauze packing in profuse intra-abdominal hemorrhage in which every other allowable means known to him would have been a positive failure. In this instance the peritoneal cavity after the removal of the gauze tampon was dry and free from odor, and he now believed that if he had then finally closed the wound, not introducing any drainage-tube at all, the patient would have recovered.

In conclusion, Dr. Boldt said that no one could be more opposed than he to the indiscriminate removal of the appendages, which had unnecessarily unsexed so many young women. Even should pyosalpinx exist, if the distention of the tube was slight and gave rise to no morbid symptoms it was the wiser plan to wait, in the hope that the pus would become inert by undergoing cheesy degeneration. In other cases, where the question of operation arose, massage employed after the method of Brandt was an excellent means to diagnosticate the patency of the tube, and should a communication exist between the tube and uterus, it constituted, if properly employed, a very valuable-adjunct in the treatment. It might be, however, a very dangerous procedure in this disease in the hands of an inexperienced manipulator.

Dr. Carl Zeiss, the celebrated optician, founder and owner of the great microscope factory in Jena, has just died at the age of seventy-three.

CORRESPONDENCE.

A SUCCESSFUL CASE OF PARTIAL LARYNGECTOMY FOR CANCER.

To the Editor of THE MEDICAL NEWS,

SIR: In writing you little more than a year ago, from Berlin, I described at some length an operation for partial extirpation of the larynx, performed by Hahn at the Frederickshain Hospital. The patient was a man, thirty-seven years old, a Mr. K., from Danzig, who had for some time been suffering with an ugly growth on the left vocal cord. He had consulted my friend, the well-known Dr. Tomwaldt, of Danzig, who, recognizing the nature of the growth, had sent him to Berlin. Having seen the operation itself, and having visited the gentleman several times subsequently, I was interested to know some of the particulars about *his death*, having read of it in several papers; but more especially had I noted it, since in Mackenzie's brochure, page 243, case 130, this patient was reported as *Dead—four weeks after operation.*

I spoke to Dr. Tomwaldt about the case, and expressed my regret, in reply to which he informed me, much to my surprise, that the man was not only *not dead*, but alive and perfectly well, and at the present speaking in Danzig.

The next day, through the courtesy of Dr. Tomwaldt and the gentleman himself, I had the pleasure of making a thorough examination of his throat, which is in good condition, with no sign of further trouble. Moreover, his voice is very fair, though, of course, hoarse.

Hahn removed, in this case, the entire left half of the larynx, the operation being very thorough, for the growth had been in a short time very active. The operation was performed November 9, 1887, and the patient has every prospect of a long life. Now at the time of the operation, the growth was infinitely larger than that in the throat of the Crown Prince, when Mackenzie operated in May, 1888.

That such a gross error as this should have been made in Mackenzie's book, is a matter of surprise.

Respectfully yours,

F. DONALDSON, JR.

DANZIG, POMERANIA, January 15, 1889.

THE WEST VIRGINIA MEDICAL ACT.

To the Editor of THE MEDICAL NEWS,

SIR: In your editorial (January 26th) on "States may Regulate the Practice of Medicine," based on the decision of the U. S. Supreme Court, in the case of F. M. Dent, you make a verbal error calculated to mislead.

In the section of our law classifying those permitted to practise, the second class were "those who have practised medicine in this State *continuously* for a period of ten years prior to the eighth day of March, 1881," not simply been in the practice of medicine *ten years* in the State, as *you* state it.

This class included some highly qualified medical men of advanced age, who in former years could not avail themselves of a collegiate education; as well as a large number of very poorly qualified men, who took up the practice of medicine without any qualifications whatever of study.

This class is rapidly being eliminated from the ranks of the profession as time goes on, by death and removal. So now virtually we have but two classes: First, "all who are graduates of a reputable medical school in the school of medicine to which the person desiring to practise belongs." Second, those who, not being such graduates, have passed examination before one of the State Examining Boards.

Gradually the requirements in these examinations have been raised, until now, I believe, a percentage of 85 of correct answers is necessary to pass the examiners; and the first course student finds it easier to go on and complete his course at college, than to obtain a certificate from the State Board.

Under the action of the law the status of the profession has been raised; our State virtually rid of the presence of itinerant quacks; and by an amendment passed in March, 1887, rid to a great extent of the itinerant vendors of medicines; such as delight to attend the presence of any gathering of people, as on Court days, etc.; also the bands of Indians under control of white vendors, etc., who, a few years ago, were visiting our towns, prescribing and evading the law, by professing to be simply selling their wares.

Perhaps some day we will advance a step farther and come into line with the mother State, Virginia, and require all to pass a State examination. Our State Board "may refuse certificates to individuals guilty of malpractice or dishonorable conduct, and may revoke certificates for like causes;" but cannot revoke certificates for unprofessional conduct, as resorted to *by charlatans* and *ignorant impostors*. We can only reach the travelling charlatan by our tax of fifty dollars per month, or fraction of a month, that he desires to practise in a county. If he becomes a resident physician, no matter how brazen his charlatanry, how *audacious* his lying advertisements, the State Board cannot reach him, as our legislature refused two years ago to allow unprofessional conduct as a cause of revoking a certificate. Perhaps some day we may arrive at that.

Even in Illinois the authorities have had trouble in enforcing that provision.

Respectfully,

W. H. SHARP, M.D.

VOLCANO, WOOD CO., WEST VIRGINIA,
February 1, 1889.

NEWS ITEMS.

A Medical Examiners' Bill.—The following bill has been introduced into the State Legislature of Pennsylvania:

An act to establish a State board of medical examiners and licensers, and to define the powers and duties of such board.

Section 1. Be it enacted by the Senate and House of Representatives of the Commonwealth of Pennsylvania, in General Assembly met, and it is hereby enacted by the authority of the same: That within six months after the passage of this Act, the Governor shall appoint a State Board of Medical Examiners and Licensers, consisting of nine members, three of whom shall serve for one year, three for two years, and three for three years, and hereafter he shall each year appoint three members to serve for three years in place of those whose terms then expire. They shall be graduates of some legally chartered college or university having the power to confer medical degrees, who shall have practised medicine or surgery for a period not less than five years, but none of whom shall be members of the faculty or staff of any medical college or university. Provided, that in the appointment of the said Board, the members shall be chosen from lists of names, each list containing the names of not less than eighteen registered physicians, submitted by the State Medical Societies of the Commonwealth of Pennsylvania. In default of the submission of any such lists, the appointments shall be made by the Governor at his discretion from among the registered physicians of the Commonwealth having the qualifications specified in this section. Each member of the said Board shall receive a certificate of appointment from the Governor, and shall file the same within thirty days with the Prothonotary of the Court of Common Pleas of the county in which said member is registered under existing law.

Section 2. The said Board shall be known by the name and style of THE STATE BOARD OF MEDICAL EXAMINERS AND LICENSERS OF THE COMMONWEALTH OF PENNSYLVANIA, and shall have a common seal and may make and adopt all necessary rules, regulations, and by-laws not inconsistent with the Constitution and laws of this Commonwealth, or of the United States, and shall have power to locate and maintain an office for the transaction of its business. Five members of the said Board shall constitute a quorum.

Section 3. Upon the organization of the said Board, it shall be determined by lot which three members shall serve for a term of one year, which three for a term of two years, and which three for a term of three years. Every appointment to fill a vacancy or vacancies in the said Board shall be for the unexpired term, and the said vacancy or vacancies shall be filled by the Governor within sixty days after notification of the same, in accordance with the provisions ofSection 11 of this Act; and he shall have power to remove any member of said Board for criminal, scandalous, or dishonorable conduct.

Section 4. The said Board shall organize at Harrisburg upon the first Tuesday of January, A. D. 1890, and shall elect from its own number a President and a Secretary who shall also act as Treasurer, both of whom shall hold their offices for the term of one year, or until their successors are chosen.

Section 5. The members of the said Board shall each receive a salary not exceeding three hundred dollars per annum, to be paid out of the fees for examination. The Secretary and Treasurer shall receive an additional salary, to be fixed by the Board, and shall file with the President of the Board a bond in the sum of one thousand dollars for the faithful performance of his duties. The necessary expenses of the said Board shall also be paid out of the fees, except as provided in Section 12 of this Act, and any balance remaining from the fees after the disbursements herein specified shall be paid into the treasury of the Commonwealth.

Section 6. The Board shall examine all applicants for license to practise medicine or surgery in this Commonwealth, who are properly qualified according to the provisions of Section 7 of this Act; and no one shall be excluded or rejected on account of adherence to any special system of practice. It shall hold two stated meetings each year, one at Pittsburg on the first Tuesday in April,

and one at Philadelphia on the first Tuesday in May respectively, and may hold special meetings at such times as it may deem proper. All examinations, except as to manipulative procedures, shall be conducted in writing, and all examination papers, together with the reports and action of the Examiners thereon, shall be preserved among the records of the said Board for a period of five years, during which time they shall remain open for inspection at the office of the said Board.

There shall be examinations in anatomy, physiology, chemistry, toxicology, pathology, hygiene, principles and practice of medicine, surgery, and obstetrics, and each applicant, upon receiving from the Secretary of the Board an order for examination, shall draw by lot a confidential number, which he or she shall place upon his or her examination paper, so that when said papers are passed upon by the Examiners the latter shall not know by what applicant said papers have been prepared; and upon each day of examination all candidates shall be given the same set or sets of questions.

Section 7. Any person, on paying ten dollars to the Secretary of the said Board, and on presenting satisfactory proof of being over twenty-one years of age, of good moral character, and of having received a sufficient preliminary education, as defined by said Board, and a diploma from some legally incorporated medical college or university having authority to confer degrees in medicine, shall be entitled to examination by the said Board; and, in case of failure at any such examination, shall have the privilege of a second examination, without the payment of any additional fee.

Each applicant who shall have passed a satisfactory examination, shall receive from said Board under seal a license to practise medicine and surgery in the Commonwealth of Pennsylvania, and the said Board may at its discretion grant licenses without examination to persons holding licenses from similarly constituted Board of Examiners or Boards of Health in other Commonwealths.

Section 8. The Secretary shall record in a book to be kept for the purpose in the office of the said Board, the name and age, sex, residence, date, and place of graduation of each applicant, together with the date of examination, the examination number, the examination average on each branch, the general average, and date of issue of license, in case such license is granted. Said book shall be open to public inspection. And on or before the last day of December of each and every year, the said Board shall publish, or cause to be published, a list of the names and addresses of such persons as shall have received licenses from the said Board, within twelve months immediately thereto preceding.

Section 9. After the first day of February 1890, no person shall enter upon the practice of medicine or surgery in the State of Pennsylvania unless he or she has complied with the provisions of this Act, and shall have exhibited to the prothonotary of the Court of Common Pleas of the County in which he or she resides a license duly granted to him or her by the said Board of Examiners and Licensers, whereupon he or she shall be entitled upon the payment of one dollar to be duly registered in the office of the prothonotary of the Court of Common Pleas in said county; and any person violating the provisions of this Act shall be guilty of a misdemeanor, and upon conviction thereof in the Court of Quarter Sessions of the County where the offence shall have been committed, shall pay a fine of not less than fifty, nor more than five hundred dollars for each offence.

Section 10. Nothing in this Act shall apply to commissioned medical officers of the United States Army or Navy, or of the United States Marine Hospital Service, nor to any member of the house, or resident staff of any legally chartered medical college, or university, or hospital during his term of service therein; nor to any physician of other States meeting duly registered physicians of this State in consultation; nor to those practising dentistry exclusively; and nothing in this Act shall be construed to prohibit the practice of medicine and surgery by any practitioner who shall have been duly registered before the first day of February, 1890, according to the terms of the Act entitled "An Act to provide for the Registration of all Practitioners in Medicine and Surgery," approved the eighth day of June, 1881.

Section 11. For the purpose of this Act, the words "practise medicine or surgery," shall mean to treat or attend any person for money, gift, or reward.

Section 12. The sum of one thousand dollars is hereby appropriated to meet the necessary and legitimate expenses of the said Board for the year A. D. 1890.

Section 13. Section 4 of "An Act to provide for the Registration of all Practitioners of Medicine and Surgery," approved the eighth day of June, Anno Domini 1881, is hereby repealed.

CORRIGENDUM.

In our issue of December 29, 1888, in Dr. Dale's "Notes on the Use of Strophanthus," page 716, at the end of the tenth line, insert *not*.

OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY, FROM JANUARY 29 TO FEBRUARY 4, 1889.

KILBOURNE, HENRY S., *Captain and Assistant Surgeon* (U. S. Army).—Will accompany Battery "E," First Artillery, changing station from Vancouver Barracks to Presidio, San Francisco, California, as medical officer, and, upon completion of this duty, will report to the commanding general Division of the Pacific, for further orders.—Par. 2, *S. O. 6, Headquarters Department of California, Vancouver Barracks*, January 22, 1889.

By direction of the Secretary of War, the leave of absence on surgeon's certificate of disability, granted HENRY G. BURTON, *Captain and Assistant Surgeon*, in Special Orders No. 19, January 24, 1888, from this office, is extended six months, on surgeon's certificate of disability —Par. 8, *S. O. 22, A. G. O., Washington*, January 26, 1889.

OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF THE MEDICAL CORPS OF THE U. S. NAVY, FOR THE WEEK ENDING FEBRUARY 2, 1889.

SCOTT, H. B., *Passed Assistant Surgeon* —Detached from the Naval Hospital, Mare Island, California, and granted one year's sick leave.

THE MEDICAL NEWS *will be pleased to receive early intelligence of local events of general medical interest, or of matters which it is desirable to bring to the notice of the profession.*

Local papers containing reports or news items should be marked.

Letters, whether written for publication or private information, must be authenticated by the names and addresses of their writers—of course not necessarily for publication.

All communications relating to the editorial department of the NEWS *should be addressed to No. 1004 Walnut Street, Philadelphia.*